Hamilton Niagara Haldimand Brant **LHIN**

Dramatically Improving the Patient Experience through Quality, Integration and Value

2015-2016 Annual Report

Ontario
Local Health Integration Network

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Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

At the time of last year's Annual Report, the Minister's *Patients First: Action Plan for Health Care*, had just been released. The Action Plan, which represents the next phase of modernizing and improving Ontario's health system, builds on the foundation of the original Action Plan from 2012 and sets a clear direction to put people at the centre of the system by focusing on patients' needs first.

In advance of our work in 2015-16, the LHIN undertook a 'refresh' of our Strategic Health System Plan (SHSP) and reconfirmed our commitment to dramatically improving the patient experience through quality, integration and value. The refresh process also identified the importance of strong, engaged primary care and home and community care sectors that integrate into a continuum of services focused on meeting the needs of people. These themes were also featured prominently in the Minister's *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, discussion paper released at the end of 2015.

While the Discussion Paper was intended to initiate a dialogue and solicit opinions from system users and stakeholders on how to make our health care system more integrated, accessible and better for patients, it also served to affirm the Government's commitment to improving integration of all health care services across our communities.

Both the Action Plan and the overarching goals presented in the Discussion Paper align closely with our SHSP, which has guided our work since 2012 and continues to ensure our gaze is firmly focused on our strategic aim and strategic directions.

Strategic Aim

Dramatically improving the patient experience through Quality, Integration and Value.

Strategic Directions

1. *Dramatically improving the patient experience by embedding a culture of quality throughout the system.*
2. *Dramatically improving the patient experience by integrating service delivery.*
3. *Dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.*

While we know there is a still lot of work to do, we have made significant steps in the right direction. Our Annual Report is an opportunity to bring a year's worth of work together in one place – to share with our community the work that has been accomplished and the work still underway. Here are just a few of the highlights you'll read more about in the pages ahead:

- **Quality Improvement** continued to be a primary focus as the LHIN executes its Strategic Health System Plan. For the third year, providers were required to develop and submit quality plans outlining their goals

and initiatives with reviews showing that 91% had clear quality plans with identified improvement initiatives and measures.

- New initiatives around **Mental Health and Addictions** are yielding very positive results including regional successes related to the LHIN-wide expansion of Mobile Crisis Rapid Response Teams into areas including Brantford, Burlington, Niagara and Norfolk. In each community the mobile teams, which pair mental health professionals with specially trained police officers to better respond to emergency calls involving people in crisis, are meeting their objectives of decreasing the number of people taken into police custody and to the hospital, linking people in crisis to community supports and reducing the amount of time officers are spending at hospital.
- The LHIN maintained its focus on migrant agricultural workers as a target population as it worked to improve population health outcomes by addressing **Health Equity** and eliminating barriers to accessing health care among vulnerable or marginalized groups. Enhanced funding enabled the development of three new primary health clinics targeting workers in Hagersville, Brantford and Vineland communities.
- Based on demonstrated success, the **Integrated Comprehensive Care Program** (ICCP), pioneered by St. Joseph's Healthcare Hamilton, was among six projects to receive Ministry funding as part of the first wave roll-out of "Bundled Care" funding models. Beginning with Joseph Brant Hospital, Hamilton Health Sciences and Niagara Health System, the program will expand to all LHIN hospitals by the spring of 2017, serving approximately 2,400 patients with COPD or CHF per year.
- A **Seniors Mobile Assess Restore Team** model was implemented across six hospital sites, with the goal of improving and preventing further functional decline in high-risk seniors. Results show improved outcomes among patients served, including significant increases in function and in percent of patients discharged home, as well as decreases in average length-of-stay and in days spent waiting in hospital to go to a complex/restorative care program.
- The **Transitional Care Program** was expanded to 15 sites in 2015-16 for a total of 196 beds located in Hamilton, Burlington, Niagara and Brant communities. The program, which provides an alternative, community-based option for individuals who are medically stable and ready for discharge from acute care hospital beds but who are not ready or unable to return home, has accumulated nearly 30,000 days which translate to avoided hospital alternate level of care (ALC) days.

As you can see from these six examples, we are not doing this work alone. The HNHB LHIN staff and Board rely heavily on our health care partners across our region and we are grateful for their dedication to improving the delivery of health care for our citizens. Through avenues like our *Voices in the Community* video series, we are committed to supporting our partners and sharing their innovative work and successes through the voices and experiences of patients, clients, and caregivers. Their stories demonstrate what is possible when we – the LHIN, health service providers, citizens and stakeholders – **work together with a common vision.**

We look forward to continuing on our journey together as we strive to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. The work we are doing is dramatically improving the patient experience - thank you for keeping our patients and their families at the centre of your thinking and your work.

Sincerely,

Donna Cripps
Chief Executive Officer

Michael Shea
Board Chair

The HNHB LHIN Board of Directors

From left to right: *Bill Thompson, Dominic Ventresca, Laurie Ryan-Hill, Michael Shea, Ruby Jacobs, Helen Mulligan, Mervin Witter, Madhuri Ramakrishnan*

Michael Shea, Chair*
Appointed October 28, 2010 Term: 3 years
Re-appointed October 27, 2013 Term: 3 years
*Appointed Chair June 2, 2011

Mervin Witter, Vice Chair**
Appointed June 2, 2011 Term: 3 years
Re-appointed June 2, 2014 Term: 3 years
**Appointed Vice Chair effective March 19, 2016

Laurie Ryan-Hill, Vice Chair***
Appointed May 17, 2011 Term: 3 years
Re-appointed May 17, 2014 Term: 3 years
***Appointed Second Vice Chair effective March 30, 2016

Helen Mulligan, Member
Appointed June 17, 2010 Term: 3 years
Re-appointed June 17, 2013 Term: 3 years

Bill Thompson, Member
Appointed May 13, 2015 Term: 3 years

Dominic Ventresca, Member
Appointed May 27, 2015 Term: 3 years

Madhuri Ramakrishnan, Member
Appointed February 24, 2016 Term: 3 years

Transitions in Board Membership

Having completed the allowable two three-year terms on the Board of Directors, Ruby Jacobs ended her tenure on March 19, 2016. Ruby was a valued member of the Board who also served as Vice Chair and Quality and Safety Committee Chair. With Ruby's departure, Mervin Witter was appointed Vice Chair and Quality and Safety Committee Chair effective March 19, 2016, and Laurie Ryan-Hill was appointed Vice Chair effective May 30, 2016.

Relationship Between the Board and Leadership Team

As of March 31, 2016, the HNHB LHIN Leadership Team included the CEO and Directors of Communications, Community Engagement and Corporate Services, Health System Transformation, Access to Care, Quality and Risk Management, Finance, Health Links and Strategic Initiatives, and Physician Lead, Clinical Health System Transformation.

Leadership Team members attend the regular Board business meetings, including the Audit, and Quality and Safety Committees, and Board education meetings, as well as present monthly verbal and written reports to the Board on the activities in their respective portfolios.

Led by the CEO, and guided by the five-year Strategic Health System Plan (SHSP), three-year Integrated Health Service Plan (IHSP) and Annual Business Plan (ABP), the Leadership Team is responsible for the strategic operations of the organization and ensures the strategic aim and directions of the SHSP are at the forefront of the planning, integration and funding recommendations to the Board.

The Board provides ongoing direction to the CEO through:

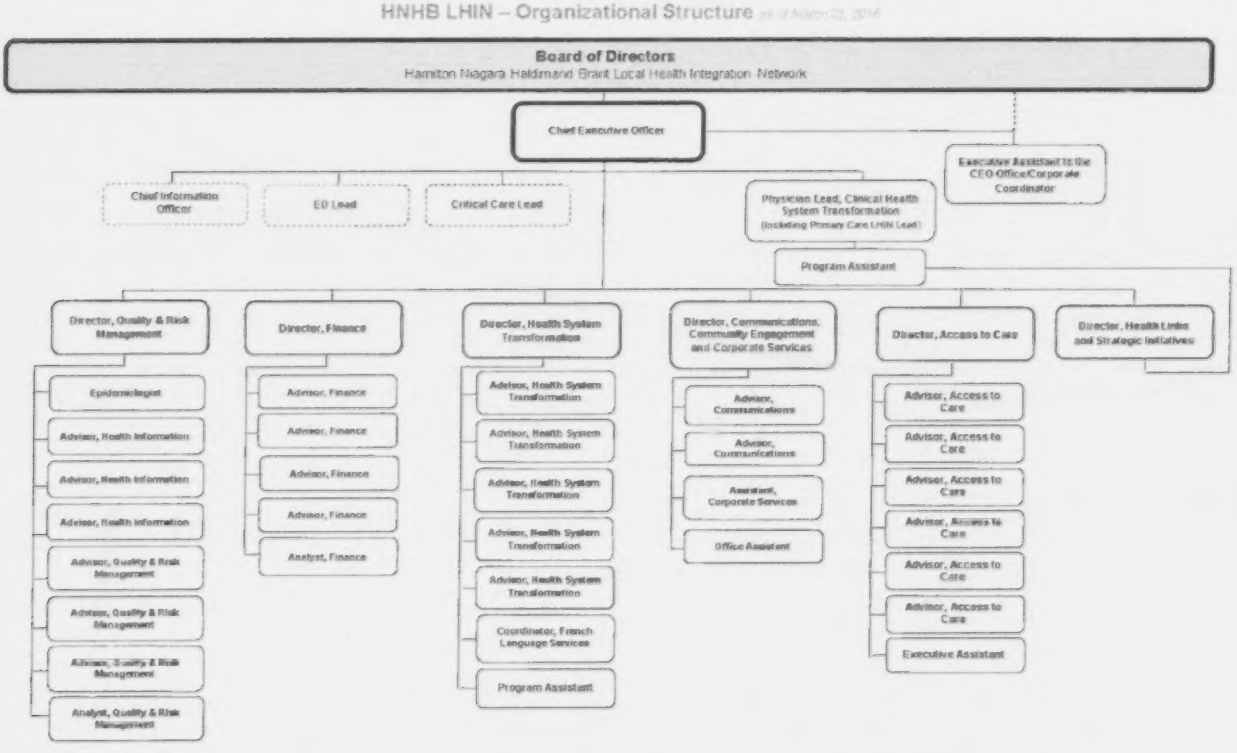
- Regular business and education meetings;
- Board committees;
- Policy direction; and,
- Performance appraisal.

Continued Evolution of the HNHB LHIN

Our Organization

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren – and the LHIN's strategic aim of dramatically improving the patient experience through quality, integration and value. It is this vision and strategic aim that guide staff in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff is committed to building capacity and sharing knowledge through participation in local, provincial, and national activities. Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.

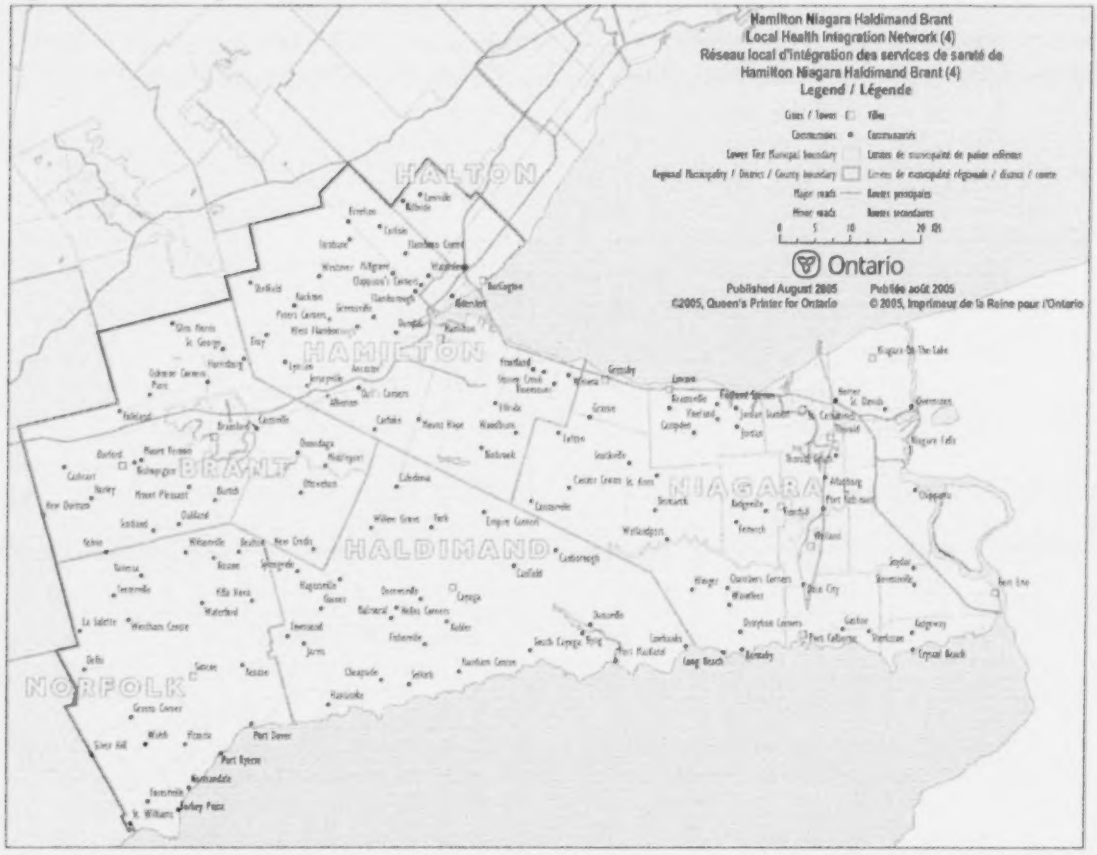


HNHB LHIN Population

Demographics

The HNHB LHIN encompasses both rural and urban areas and is approximately 6,500 km^2 in size. The LHIN is home to approximately 1.44 million people or 10.4% of the population of Ontario and is projected to grow 7.4% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

Figure 1 – LHIN 4 Map



Socio-Demographic Characteristics

The LHIN's population is aging. More than 260,000 people age 65 or older live in the LHIN and this number is projected to increase to approximately 360,000 by 2025 – that is an increase of more than 35%. Among seniors, the largest growth will be those 75 years and older *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The HNHB LHIN has a diverse population. For 17% of residents, neither English nor French is their first language. Francophone, First Nations, Inuit, Métis, and urban Indigenous people are recognized populations in the HNHB LHIN. Compared to the Ontario average the HNHB LHIN has a lower

percentage of immigrants (19%) and visible minorities (10%) *(2011, National Household Survey, Statistics Canada).*

About 2.4% of the LHIN population is defined as Francophone. Almost 80% of the LHIN's Francophone population resides in Hamilton and Niagara. In Niagara, Welland and Port Colborne have the highest percent of Francophone population compared to the overall population among communities within the LHIN *(Source: 2011 Census of Canada, Statistics Canada).*

There are two First Nations reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Indigenous population in the LHIN is approximately 28,000 people, approximately 50% of whom live on reserve *(Source: Community profiles, Aboriginal Affairs and Northern Development as of February 2015).*

In many ways, the LHIN population is similar to the provincial population on a variety of socio-demographic characteristics. Within the LHIN however, there are some significant differences between and within geographic regions. While the HNHB LHIN has a similar population proportion of low-income families as Ontario, Hamilton rates of low income are higher than the provincial average. Compared to the Ontario average, the LHIN has a higher percentage of lone parent families and a lower percent of adults with high school and post-secondary education.

Figure 2 – HNHB LHIN Socio-Demographic Characteristics

Socio-Demographic Characteristic	HNHB LHIN	Ontario
Total Population (2015)*	1,437,426	13,135,063
Senior population, age 65+ (2015)*	18.4%	13.9%
Population who report English as their mother tongue	81.3%	70.4%
Population who report French as their mother tongue	2.3%	4.4%
Population who are immigrants	19.2%	28.5%
Populations who are visible minorities	10.3%	25.9%
Population reporting Indigenous identity	2.8%	2.4%
Unemployment rate (age 15+)**	8.1%	8.3%
Prevalence of low income in 2010 based on after-tax low-income measures	13.2%	13.9%
Population (age 25-64) with completed post-secondary education	61.4%	64.8%

*(Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO. **2011 Labour Force Survey. Remaining indicators based on 2011 Census of Canada and 2011 National Household Survey, Statistics Canada.)*

Health Status

Health can be measured as perceived or self-reported indicators as well as the presence or absence of disease or injury. Self-reported health can show aspects of health not captured in other measures. More than 13% of LHIN residents rate their health as 'fair' or 'poor', which is higher than Ontario's rates. In addition, more LHIN residents say they are limited in their activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities *(Source: Statistics Canada, Canadian Community Health Survey, 2013).*

Illness, Disease and Death

LHIN residents have a higher prevalence of high blood pressure, chronic obstructive pulmonary disease (COPD), and arthritis compared to the province. Approximately 20% of HNHB LHIN residents have been diagnosed with high blood pressure or arthritis, and 6% with COPD. The percentage of residents with asthma is 8% and diabetes is nearly 8%, which means that the HNHB LHIN rates are slightly higher than Ontario rates *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Death rates reflect the overall health of the population. Ischemic heart disease, dementia and Alzheimer disease, lung cancer, and stroke were the top four leading causes of death in the HNHB LHIN. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e. before age 75). The rate of potential years of life lost within the HNHB LHIN is 11% higher than provincial rate *(Source: Statistics Canada, 2011; CIHI Health Indicators Interactive Tool, 2010)*

Health Practices and Preventive Care

Poor health practices, such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. The rates of smoking are 24% in the HNHB LHIN. This is the highest rate in the province and is significantly higher than the provincial average of 18%. However, the rates vary significantly within the LHIN from 9.9% in Ancaster to 37% in Hamilton Urban Core. Relative to the province, more people in the HNHB LHIN have a body mass index (BMI) indicating they are overweight or obese. *(Source: Statistics Canada, Canadian Community Health Survey, 2013).* In 2013, there was a slightly lower percentage of adults in HNHB LHIN reporting that their alcohol consumption was heavy when compared to the provincial average.

Activities that promote health, prevent disease and reduce the risk of injury are important elements in the health and wellness of a population. These activities require individuals to be engaged in their health care and can be facilitated through an effective relationship with a primary physician. More than 95% of adults living in HNHB LHIN reported having a primary care provider, which is slightly higher than the Ontario rate. Preventive health care services, such as immunizations and regular health screenings, can help prevent and find disease early and reduce illness and death over the long-term. Approximately 33% of HNHB residents received a flu shot in 2013, which is similar to the Ontario average *(Source: Health Care Experience Survey, Ministry of Health and Long-Term Care, 2014).*

Health Service Providers

As of April 1, 2015, the HNHB LHIN held 189 Service Accountability Agreements with health service providers, funding them to deliver health care services within the LHIN. This included nine hospital corporations, 85 long-term care homes, and 95 community support service agencies.

Summary

Relative to Ontario, the LHIN has a significantly higher percentage of:

- People reporting health as 'fair' or 'poor'
- People reporting activity limitations due to pain or discomfort
- People with a BMI indicating they are overweight or obese
- People who smoke on occasional or daily basis
- People diagnosed with arthritis
- People diagnosed with COPD
- People diagnosed with high blood pressure
- People diagnosed with asthma
- People diagnosed with diabetes
- People reporting mental health as 'fair' or 'poor
- Potential years of life lost from preventable causes
- Premature mortality and potentially avoidable mortality
- Ambulatory care sensitive conditions

Engaging our Communities

Community engagement is a core function of the LHINs and is written into the *Local Health System Integration Act (LHSIA), 2006* – the legislation that created LHINs. As part of its work, the HNHB LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with members of the Indigenous and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

Working towards the development of its 2016-19 Integrated Health Service Plan (IHSP), the HNHB LHIN engaged with health care consumers from across the region, including re-convening the Citizens' Reference Panel (CRP) for a series of work group sessions. The goal of the engagement activities was to understand the needs and concerns of health system users and ensure their priorities were reflected in the final IHSP.

Two engagement sessions focusing on the development of the 2016-19 IHSP were held, one in English for the broader CRP group in June 2015 and one in French for the Francophone sub-panel in August 2015. In total, 30 residents participated in the sessions. Following educational updates, the panels were asked to identify their preferred future state for several themes, which had been identified in advance through a questionnaire. More information about the CRP, including the detailed findings from the group can be found on the HNHB LHIN website at the following link: http://www.hnhblhin.on.ca/en/communityengagement/CitizensReferencePanel.aspx.

On December 17, 2015, the Ministry of Health and Long-Term Care released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, a discussion paper outlining significant structural changes to the health system. The discussion paper focused on four interconnected and overarching themes:

1. *More effective integration of services and greater equity.*
2. *Timely access to primary care, and seamless links between primary care and other services.*
3. *More consistent and accessible home and community care.*
4. *Stronger links between population and public health and other health services.*

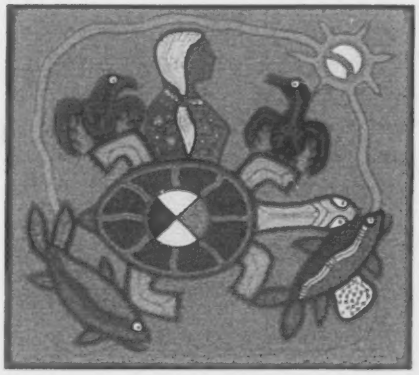
As part of the provincial consultation process to gather feedback from stakeholders, including providers, patients and caregivers, the HNHB LHIN conducted regional consultations during the months of January and February and submitted the feedback to the Ministry at the end of February.

The HNHB LHIN collected feedback in many ways, including online questionnaires, webinars, direct consultations with physician groups and Health Links partners, stakeholder meetings and written submissions from provider organizations, and throughout this process, engaged with more than 1,200 individuals. An overview of the engagement activities, including all of the feedback received is available on the HNHB LHIN website at: www.hnhblhin.on.ca/PatientsFirstProposal.

Indigenous Health Engagement

Health and wellness among Indigenous Peoples is strongly linked to cultural identity, community empowerment, and a widely held belief in the interconnectedness of all things. It is essential that approaches to health care acknowledge, respect, and incorporate aspects of these linkages when caring for Indigenous patients and their families. Meaningful engagement with First Nations and urban Indigenous communities gives patients and families the opportunity to share their stories and have their experiences shape current and future health programs and services. The knowledge gathered from community experiences is fundamental in developing the LHIN's population-based strategy aimed at improving the health and wellness of Indigenous Peoples. Through harmonizing the efforts of traditional and non-traditional health practices, solutions can be created that align with cultural identity, holistic health and community values.

Collaboration with the HNHB LHIN's Indigenous Health Network (IHN) enabled the development of culturally safe and inclusive health care environments that translate into improved patient experiences and positive outcomes. The IHN met monthly to share expertise, convey local health issues, and provide input to the LHIN regarding approaches to planning, community engagement, and system performance.
In April 2015, the IHN identified a new 2015-2018 Strategic Plan based on the health needs of local communities and the health-specific recommendations identified in the Truth and Reconciliation Commission of Canada's Final Report and Calls to Action. The five key priorities identified were:



1. *Indigenous Cultural Competency*
2. *Access to Traditional Healing*
3. *Strengthening the Family Unit*
4. *Mental Health & Addictions and Suicide Prevention; and*
5. *Chronic Disease Management & Prevention*

To support these priorities the IHN engaged in a variety of activities during 2015-16 including:

- The review, evaluation, and endorsement of Ontario's Indigenous Cultural Safety (ICS) Training as a positive first step towards improving cultural safety in health care settings.
- The facilitation of an Aboriginal Patient Navigator (APN) Service Coordination Session with 50 staff from Indigenous organizations to develop a path forward for patient navigation that creates a more integrated, collaborative and sustainable system to provide Indigenous Peoples with the advocacy and support they need to access the best care possible.
- The establishment of a partnership between De dwa da dehs nye>s Aboriginal Health Access Centre (DAHC) and Southern Ontario Aboriginal Diabetes Initiative (SOADI) with two Niagara Diabetes Education Programs and St. Joseph's Healthcare Hamilton Teleophthalmology Program to enhance the services offered through SOADI's model of care called 'Team Fridays'. This model has increased access to primary care and diabetic services at the same location where

clients can also receive traditional healing, diabetes education, retinal screening, healthy eating seminars, and foot care clinics.

- The implementation of a communication strategy to increase community awareness of Indigenous health and social service organizations that provide programs and services designed, developed and deliver by Indigenous Peoples. The plan included the launch of a Public Service Announcement aired on the local Hamilton television station, distribution of brochures to Brant Community Healthcare System, Hamilton Health Sciences, Niagara Health System and St. Joseph's Healthcare Hamilton, and the development of an IHN website that can be found at www.ahn-hnhb.ca.

Cultural Safety

With the endorsement of the IHN, the LHIN developed and initiated a plan to broaden access to Ontario's Indigenous Cultural Safety (ICS) training to mainstream health service providers. In 2015-16, a total of 160 individuals participated in ICS training, including staff from Brant Community Healthcare System, Hamilton Health Sciences, Niagara Health System, Norfolk General Hospital, St. Joseph's Healthcare Hamilton and five Diabetes Education Programs. This training offers a platform for participants to develop their knowledge of Ontario's Indigenous Peoples within the context of health care and then take a deeper look at how this knowledge translates into the way they provide care. The training is founded on principles of respect, safety, and trust, and aims to create an interactive and facilitated environment for health professionals.

The LHIN continues to support the need for broader expansion of ICS training as a necessary means to provide the best care possible for Indigenous Peoples in a way that considers and respects their cultures and beliefs.

Patient Navigation

Three full-time Aboriginal Patient Navigator (APN) positions are currently funded through De dwa da dehs nye>s Aboriginal Health Access Centre (DAHAC) in three LHIN zones: Hamilton, Brantford and Niagara. The role is intended to work with Indigenous and mainstream health and social service organizations, the HNHB Community Care Access Centre (CCAC) and hospitals across the LHIN to support Indigenous clients, caregivers and their families as they navigate the health care system. Between April and December 2015 this program helped 265 individuals from across the LHIN access services to address their physical, mental, emotional, and spiritual wellbeing.

The Child & Youth Mental Health Aboriginal Patient Navigator Program at DAHAC and Six

Aboriginal Patient Navigators
Making a Difference:
A woman is living with advanced lung disease and needs lung transplant surgery.
After being assessed, she was found not to be a suitable candidate due to significant concerns about the stress post-surgery support would place on her family functioning and the lack of formal supports in place.
APN was contacted and held a case conference with her social worker, psychologist, and physicians.
Mental health support, home care supports, assistive devices, and emotional/social supports were put in place.
A second assessment found the woman eligible for a lung transplant and she is currently on the wait list.
(Aboriginal Patient Navigator Quarterly Report – Q2 2015-16)

Nations Health Services was supported by the LHIN in late 2014-15 and continues to provide early identification and intervention for co-occurring disorders in youth. Between April and December 2015, this program helped link 60 children and youth to specialized services for mental health and addictions such as traditional healing, psychiatry, and group programs.

Traditional Healing

In November 2015, the LHIN, in partnership with Six Nations Health and Social Services, the Ministries of Health and Long Term Care, Aboriginal Affairs, and Child and Youth Services, helped to plan and support *A Conference about Harmonizing Indigenous Wellness in Medicine and Health Practices* at Six Nations of the Grand River. More than 200 registrants and 23 speakers from across Ontario gathered with optimism and confidence that improved community partnerships can improve access to the best care that traditional and mainstream medicine have to offer for Indigenous Peoples. A report and recommendations from the conference identified key opportunities for change in the areas of decolonization, relationship building, pathways to traditional medicine and healing, cultural competency and safety, indigenous medicine practitioner training and creating safe spaces. The full list of recommendations and a copy of the report can be found on the HNHB LHIN website.

Francophone Health Engagement

The *French Language Services Act* (FLSA), Ontario, 1986, recognizes the contribution of the French-speaking population to the historical, cultural, and linguistic heritage of Ontario. The FLSA guarantees the right of French-speaking Ontarians to communicate with the government and receive services in French. Under the requirements of the *Local Health System Integration Act (LHSIA), Ontario, 2006*, the LHIN is responsible for ensuring that the French-speaking population has equitable access to a full range of health services in French. To this end, the LHIN funds, plans and promotes French language health services, and engages the French-speaking community in the process. French-speaking residents and stakeholders know their communities best and the goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Partners in Health

In 2011, the HNHB and Waterloo Wellington (WW) LHINs, and the French Language Planning Entity (FLPE) signed a five-year funding and accountability agreement. Before the renewal of the accountability agreement, the ministry undertook an evaluation of the LHIN and the FLPE model, whose primary purpose is to support the planning of health services in French. Based on the evaluation of the model's report, a new agreement is in preparation. In December 2015, the ministry reselected the *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara* to continue working with LHINs. For 2016-17, both LHINs and the Entity made a Joint Annual Action Plan (JAAP) which sets out the objectives, priorities and actions each LHIN and the FLPE will undertake in this subsequent funding year. Each LHIN's annual business plan are well aligned with the ministry's priorities which help inform the objectives set out in the JAAP.

Francophone Community Engagement

The LHIN engaged the FLPE and the Francophone community through the Citizens' Reference Panel (CRP) during the development of the 2016-19 Integrated Health Service Plan (IHSP). Among others learnings, the discussion identified the need to promote and communicate existing services in French and

the necessity of improving how Health Service Providers (HSPs) proactively offer services in French to French-speaking clients/patients

The LHIN again engaged the FLPE and the Francophone Community to provide feedback on the *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The FLPE led French sessions in Hamilton and Niagara, which ensured the voice of this population be taken into account in the designing of a renewed health care system. The feedback received was incorporated into the LHIN's submission to the Ministry and is posted on the LHIN website alongside the other feedback received.

The LHIN actively participated in community meetings and information and consultation sessions to present services available in French. HSPs were welcomed to talk about their services and to engage the Francophone community. In partnership with the FLPE and various community organizations, the LHIN promoted the active offer of French Language Services among HSPs and frontline bilingual staff.

The LHIN developed and distributed an FLS toolkit to HSPs that have been formally identified as offering services in French. This toolkit provides information on the Francophone community, its health status, needs, and ways to implement FLS that support programs enabling the provision of services in French.

Listening, Learning and Developing Services

In response to a need expressed by the community, the HNHB LHIN continues to work with the Community Care Access Centre (CCAC) to make sure that services are offered in French, and to match French-speaking clients with HSPs able to communicate in French.

The LHIN and the FLPE are developing an implementation plan to increase access to Long-Term Care (LTC) beds for the Francophone community in Hamilton.

In order to continue the exploration of solutions to improve access to health services, the LHIN facilitated the implementation of diabetes education sessions through the Ontario Telemedicine Network (OTN). In 2015, three sessions have been held by the Centre de Santé Communautaire and 14 health sites across the Province were connected.

Physician Engagement

Physician engagement is a key component in planning and implementing strategies across the LHIN. Over the past several years, this LHIN has had a variety of active physician networks, and various ad hoc groups, which include both specialists and family physicians.

The Chief Medical Leaders (CML) group has been meeting for more than seven years and is comprised of Chiefs of Staff or Vice President Medical from each LHIN hospital. The meetings review wait time data, access to care, and provide input on many of the new initiatives being implemented across the LHIN. In 2015-16, this group began to work on improving a repatriation of the Life or Limb program and preparing for potential legislative changes related to on Medical Assistance in Dying (MAID). This group also provides the opportunity for all LHIN hospitals, whether smaller hospitals or larger academic hospitals, to discuss LHIN-wide issues, including call coverage and to work together to improve the patient experience across the LHIN.

The Diagnostic Steering Committee (made up of radiologists) and their administrative colleagues are collectively working on improving standardization of protocols across the LHIN and the development of a common computed tomography (CT) referral form. Wait times for both magnetic resonance imaging (MRI) and CT are continually reviewed and strategies implemented to facilitate more appropriate access across the HNHB LHIN. This work incorporates the Choosing Wisely Canada (CWC) guidelines which have been circulated to family physicians.

The LHIN's Primary Care Network (PCN), consisting of Primary Care Physicians and the family physician HealthLink leads, regularly provides input to the clinical strategies being implemented across the LHIN and helps LHIN staff and providers better understand how meeting the needs of primary care and family physicians would help them to help their patients. Over the past year, LHIN Diabetes Education Programs (DEPs) have developed a common referral form for all primary care providers and patients can now self-refer to these programs. These changes were developed in collaboration with the Primary Care Network and have been shared with all physicians across the HNHB LHIN.
During the months of January and February 2016, more than 500 family physicians provided feedback on the Patients First Discussion Paper and members of the PCN were instrumental in assisting the LHIN to understand how best to reach those physicians . Feedback was also obtained from a variety of other consultants, allied health providers, as well as community organizations and patients.

The Health Professionals Advisory Committee (HPAC) continued to provide insights and perspective to the LHIN. Focused on optimizing interprofessional care and scopes of practice within the LHIN, in 2015-2016 HPAC focused primarily on the mental health addiction sector, and provided valuable advice and input into the LHIN's Mental Health and Addictions planning process. Over the past year, this committee has continued to provide advice for the HNHB Mental Health Strategic Plan.

HNHB LHIN's Strategic Health System Plan (SHSP) – Dramatically improving the patient experience through Quality, Integration and Value

In 2012, the Hamilton Niagara Haldimand Brant (HNHB) LHIN undertook a strategic planning process to identify those key directions which, implemented together, will transform the health care system at the local level. The strategic directions, goals and deliverables stemming from the plan have guided the work of the HNHB LHIN over the past three years.

The SHSP set out the overall aim of the HNHB LHIN to dramatically improve the patient experience through quality, integration and value.

The three key strategic directions flowing from this aim are as follows:

1. *Dramatically improving patient experience by embedding a culture of quality throughout the system.*
2. *Dramatically improving the patient experience by integrating service delivery.*
3. *Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners.*

In advance of the LHIN's work in 2015-16, the LHIN undertook a 'refresh' of the Strategic Health System Plan (SHSP), which re-confirmed the strategic aim and strategic directions. Additionally, the refresh process identified the importance of a strong, engaged primary care sector, and a strong home and community care sector, integrated into the continuum of services focused on meeting the needs of the person.

Accordingly, the HNHB LHIN Board agreed that, for 2015-16, the LHIN would maintain its strategic focus on dramatically improving the patient experience through quality, integration and value. In addition to these key directions, the HNHB LHIN also focused on primary care, home and community care, health and wellness of the population, engaged communities and future ready thinking.

System Integration – Patients First

Released by the Minister of Health and Long-Term Care (Minister) in February 2015, *Patients First: Action Plan for Health Care* represents the next phase of Ontario's plan to transform Ontario's health care system. It builds on a strong foundation set by Ontario's original *Action Plan for Health Care* released in 2012 and strengthens the government's commitment to put patients first by improving their health care experience. In December 2015, the ministry released *Patients First: a Proposal to Strengthen Patient-Centred Health Care in Ontario*, which reinforces the focus on integrating service delivery, including

primary care and home and community care. This focus will shape the direction of LHIN planning into 2016-17 and beyond.

System-wide Quality Improvement

The strategic direction of dramatically improving the patient experience through embedding a culture of quality throughout the system continues across the HNHB LHIN. The LHIN, its health service providers, and its partners are actively engaged in quality improvement efforts within individual services and programs, as well as across the health care system. A culture of always seeking opportunities to enhance the care experience, health outcomes and system performance has been fostered within the HNHB LHIN and examples of these initiatives are provided throughout this annual report.

In 2015-16, the Quality Guidance Council (QGC), chaired by the HNHB LHIN and CCAC CEOs, provided leadership and advice regarding quality efforts within the LHIN. QGC members represent all sectors of the health system and provide thoughtful insights, ideas and input to help create and sustain the culture of quality.

Quality Obligations

For the third year, all health service providers (HSPs) were developed and submitted quality plans to the HNHB LHIN outlining their goals and initiatives to improve health outcomes and the care experience for patients, clients, and residents. The quality plans were reviewed by LHIN staff and common themes identified. The reviews showed that 91% of HSPs had clear quality plans with identified improvement initiatives and measures. The themes emerging in the quality plans were similar across all sectors with some variations in the type of initiatives being addressed. The majority of hospital plans identified initiatives to improve patient satisfaction, infection control, medication reconciliation, and access to services through reducing ED wait times and acute care length of stay. Long-Term Care Homes submitted plans that included issues such as appropriate use of medications, improving communication with residents and reducing falls and pressure ulcers. Similarly, many quality plans prepared by the Home and Community Care sector included a focus on client experience, access to services and integrated care.

HSPs also submitted a board-approved policy on quality and a balanced scorecard of key performance indicators. Submission and review of these documents created opportunities for the LHIN to provide feedback and engage in an important dialogue about quality with its funded organizations.

This examination of the quality plans, scorecards, and policies will be used to facilitate information sharing and to further strengthen the connections between provider planning, performance management, and LHIN commissioning.

Patient Experience

Creating a positive health care experience for patients, residents and clients is of critical importance to the HNHB LHIN and its providers. An individual's perception of their health experience is influenced by all aspects of care and service. Building on the patient experience framework developed in 2014-15, HNHB LHIN included an obligation in the service accountability agreement schedules with all HSPs. The obligation requires providers to collect and report information regarding aspects of patient experience: overall satisfaction with the care and services received and involvement in care decisions. This creates a shared focus on patient experience and baseline data across the LHIN.

Performance Management

The Performance Accountability Policy outlines principles to guide performance management and sets out a clear relationship between the LHIN and HSPs, the role of governance in performance improvement and identifies the steps to address performance challenges.

The Policy helps answer key questions related to effectiveness, efficiency and quality:

- Are health service providers delivering what they're supposed to be delivering? (Effectiveness)
- Are health service providers delivering services as efficiently as possible? (Efficiency)
- Are there some things that other health service providers can do better? (Quality)

Performance management is crucial to ensuring the best health care services and programs are available for people when they need them. Recognizing the importance of monitoring service delivery volumes, efficiency, and good stewardship of resources the LHIN continued its efforts to create a robust performance management system. Foundational to this work were the efforts of LHIN staff and HSP leadership throughout 2015-16 to ensure high data quality and accuracy of reporting.

A new Ministry-LHIN Accountability Agreement (MLAA) was signed effective April 1, 2015. The MLAA included revised and new performance indicators and provincial targets. These indicators form the core metrics for performance management within the LHIN. The LHIN is continuing its work to identify consistent measures of health outcomes and standardized key metrics for various programs and functional centres that align with and support the local strategic directions.

Enterprise Risk Management

The LHIN uses an Enterprise Risk Management (ERM) approach to identify, assess, mitigate and communicate key risks in the LHIN.

Key elements of ERM include:

- Monitoring strategic, operational, financial and reputational risk of both the health service providers and the LHIN and it is the responsibility of staff at all levels of the organization to identify risk;
- LHIN staff will consult with LHIN leadership to determine whether a risk will be elevated to the Ministry of Health and Long-Term Care (MOHLTC);
- Risks will be brought forward to leadership on a regular basis; and,
- Each risk will be updated until the risk is mitigated through risk management plans.

The number and complexity of HSPs in the LHIN requires prioritization based on identified risks. The LHIN utilizes a methodology to rank agency risk on a quarterly basis to assess compliance with service accountability agreements, key performance indicators, and core financial indicators.

The LHIN regularly reports risks to the Board's Quality and Safety Committee and the ministry. Monitoring organizational risk is one of the ways LHINs work to ensure value for money, access to services and access to the best patient care for people and their families.

Integration – Health Links as a New Model of Integrated Care Delivery

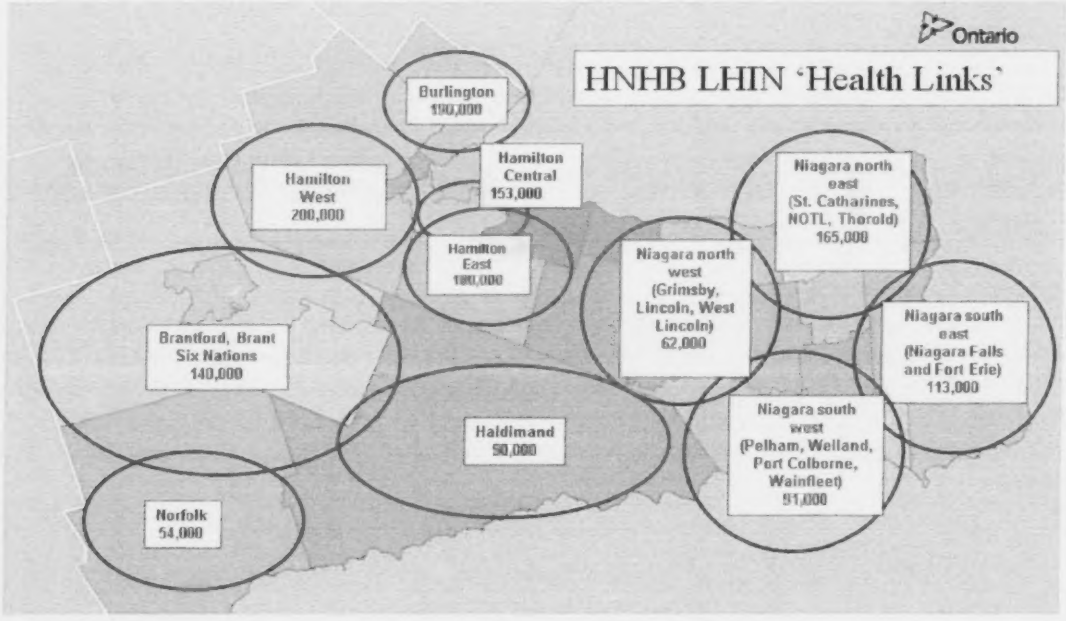
As part of its SHSP, the LHIN has identified three key strategic directions supporting its strategic aim of dramatically improving the patient experience through quality, integration and value. Improving the patient experience by integrating service delivery begins at the local level - integrating care delivery for a group of individuals - one person at a time. Integrated service delivery means the system will focus on patient-centered care including supporting the Health Link model of care.

Patients First: Action Plan for Health Care was released in February 2015 and is the next phase of Ontario's plan for changing and improving Ontario's health system. Putting patients first lays the foundation for Health Links - a model of care to improve care for high-needs patients, with an initial focus on seniors and patients with chronic conditions.

The Health Links model focuses on patient-centred goals to address the needs of people living with complex chronic conditions and needs, through collaborative coordinated care plan and more meaningful patient engagement. Health Links is a catalyst for transformational system changes that lead to a better quality of care and patient experience. It represents a cornerstone in the primary care system by connecting patients to community-based care by using resources more efficiently and effectively. Health Links respects local variations and needs, but abides by a core set of principles including:

- Patient-centered care;
- Patient engagement including patients, families and caregivers ;
- Broad provider participation;
- Alignment and integration of care transition points; and,
- Planning that incorporates all aspects of a patient's needs and objectives.

Figure 3 – HNHB Health Links Map



Foundational Work

Reflecting the geography and diversity of the LHIN population, 11 Health Links are operational in the HNHB LHIN.

Identifying the Health Link Person

The LHIN partnered with local experts to identify those people who would most likely benefit from having a coordinated care plan developed utilizing the Health Link model of care. Based on 2014-15 data more than 15,000 people met the criteria of five or more emergency department visits in the past year. In addition, Health Link coordinators developed partnerships within hospital Emergency Departments and inpatient wards to identify in real-time those patients that would benefit from a coordinated care plan.

Local Challenges, Local Solutions

A LHIN-wide strategy was developed and continues to advance the implementation of Health Links bringing together local committees and working groups to oversee and provide guidance and recommendations including:

- a Steering Committee comprised of Executive Leads to ensure alignment of local Health Link directions with provincial and LHIN priorities;
- an Operations Committee comprised of Project Leads to identify and disseminate best practices across the Health Links; and,
- Working Groups to develop a LHIN-wide approach to:
    - the reporting of standard indicators;
    - care coordination; and,
    - plan for an information technology solution in order to share the care plan with the patient and those within their circle of care.

Major Initiatives

Care Coordination

The LHIN continues to work with Health Link lead providers, partners, and stakeholders to advance the work of the Health Link model of coordinated care. This shared model brings together the health care providers in a community to better and more quickly coordinate care for patients with the greatest health care needs. In 2015-16, health providers completed more than 600 coordinated care plans for patients living with complex chronic conditions. These care plans adopt best practices related to person-centred care planning.

Community Paramedicine

The LHIN continued to facilitate partnerships between Health Links and local Emergency Medical Services teams to explore expanding the role of paramedics to better support the complex needs of patients. Emerging models within Health Links see paramedics visiting patients in their communities or at home to assist them in better managing their chronic conditions. This approach to patient care is intended to reduce visits to the hospital as well as ensure the appropriate use of primary care and community resources.

Clinical Program Integration

Continued clinical services planning directly aligns with the LHIN's Strategic Health System Plan for a local integrated health care system where individuals experience care that is coordinated, of the highest quality, cost effective and results in better outcomes for the population.

The LHIN follows a consistent process to develop LHIN-wide integrated clinical programs. This process has achieved great success with measurable outcomes as evident through the Integrated Cancer Clinical Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan. Work of the Orthopaedic, Vision and Diagnostic Imaging Steering Committees is ongoing to improve integration in these clinical areas resulting in an improved patient experience.

Success is attributed to a defined process with clear expectations, strong physician engagement and leadership, along with strong administrative and organizational leadership. Clinicians assess each patient and determine how urgent their need for treatment is, ranging from more urgent cases (Priority 1 or P1) to less urgent, non-emergency cases (Priority 4 or P4).

The key to LHIN-wide integrated clinical programs is "one program across multiple sites." All LHIN residents should have access to a coordinated program with the same approach to care delivery and the same quality standards regardless of where they live or seek their care in the LHIN. This requires increased standardization and the reduction of clinical variation between providers. This is accomplished by using common definitions and patient flow processes, common care models and quality improvement process, based on leading practices, common outcomes, goals, deliverables and metrics.

Orthopedics

The LHIN Orthopedic Leadership Steering Committee continues to lead work to sustain the quality achievements to date, as well as establish deliverables for the future. The Steering Committee is completing a review of the utilization of hip and knee replacement resources to ensure the allocations of hip and knee replacements are used efficiently across the LHIN and to examine future needs of the aging population.

The HNHB LHIN has implemented collaborative partnerships with hospitals to improve wait times and promote standardization across the LHIN for patients requiring total joint replacement. Specific emphasis has been placed on wait list management, accurate reporting of data, and referral redirection to first available surgeon through the Regional Joint Assessment Program. Partnerships have been established between HNHB LHIN facilities to ensure timely access to care after a patient has had a hip fracture, and to patients who present to a LHIN hospital when they do not have an orthopedic surgeon resource.

Monthly meetings between the HNHB LHIN and Orthopedic/Surgical Directors led to the development of a unified LHIN-wide approach to sharing best practices and successes to ensure:

- Increased accuracy of wait time data with a better LHIN-wide understanding of the variation and opportunities for improvement.
- Emphasis is placed first on booking individuals with the highest priority and then booking individuals who have been waiting the longest.
- Surgeon-specific wait times are shared with all sites across the HNHB LHIN to increase staff awareness of surgeon's with the timeliest access to surgery, in order to facilitate wait time knowledge and opportunities for referral redirections to surgeons with shorter waitlists when

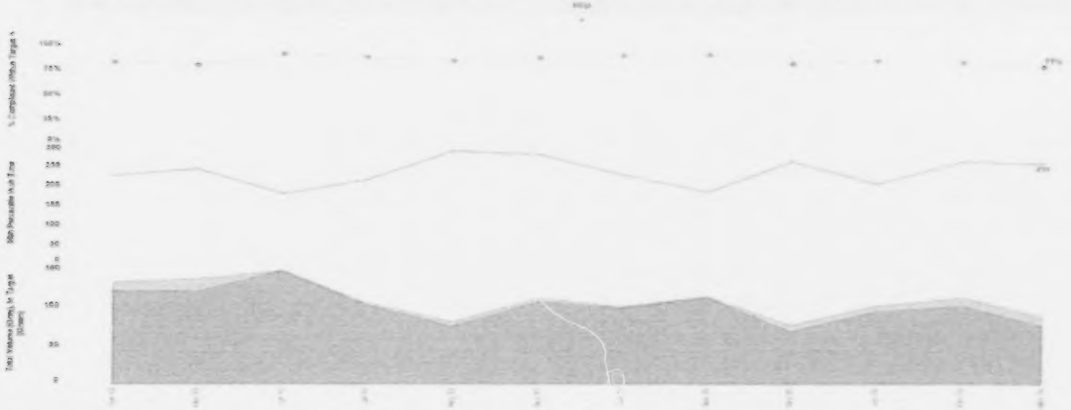
appropriate. The Niagara Health System (NHS) initiated improved transparency to the public and referring physicians of surgeon-specific hip and knee replacement wait times through the NHS website. This can facilitate a patient's referral to the first available surgeon, therefore improving access to care.

- The total number of surgeons participating in the Regional Joint Assessment Program have increased this year.
- Hip fracture partnerships between large and small hospitals were achieved to improve the management of emergency hip fractures for patients, with standardized order sets to support patient care.
- Physician understanding of the Surgeon Dashboard has been facilitated to enhance practices and understand patient wait times for Wait 1 (patient referral to specialist consultation) and Wait 2 (decision to treat with surgery to surgical completion).

Work has continued with hospitals on meeting and exceeding the wait time targets for patient access to hip and knee replacement surgery. There was a continued emphasis on looking for opportunities to reduce variation in wait times among surgeons and facilities, by redirecting patients where appropriate to a surgeon with a shorter wait time for surgery.

For example, in 2005 after deciding with their specialist to proceed with hip replacement surgery, nine out of 10 people in the HNHB LHIN waited up to 416 days, or more than 13 months. The latest results for fiscal year 2015-16 highlight greatly improved access over the long-term to these surgeries. Wait times have reduced by 156 days (or five months sooner) from the 2005 baseline (a 37.5% reduction in wait days). This means that 81% of Adult Priority 4 Hip Replacement surgeries were completed within the 182-day target in fiscal year 2015-16.

Figure 4 – HNHB LHIN Monthly P4 Monitoring: Total Hip Replacement (FY 2015-16)

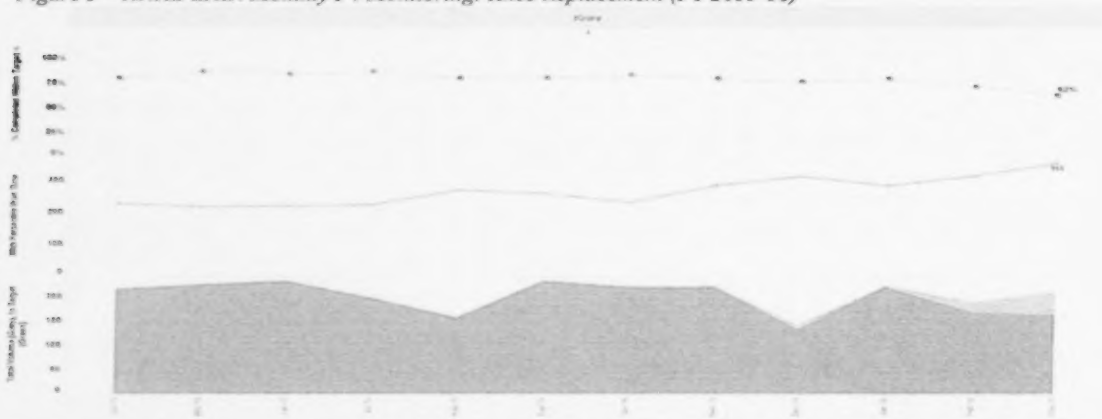


(Source: WTIS iPort Access) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

In 2005, nine out of ten people undergoing Knee Replacement Surgery in the HNHB LHIN waited up to 450 days, or over 14 months, after deciding with their specialist to proceed with surgery. The latest results highlight greatly improved access over the long-term to these surgeries. Wait times have reduced by 138 days (or four and a half months sooner) from the 2005 baseline (a 31% reduction in wait days). This

means that 71% of Adult Priority 4 Knee Replacement surgeries were completed within the 182-day target in fiscal year 2014-15.

Figure 5 – HNHB LHIN Monthly P4 Monitoring: Knee Replacement (FY 2015-16)

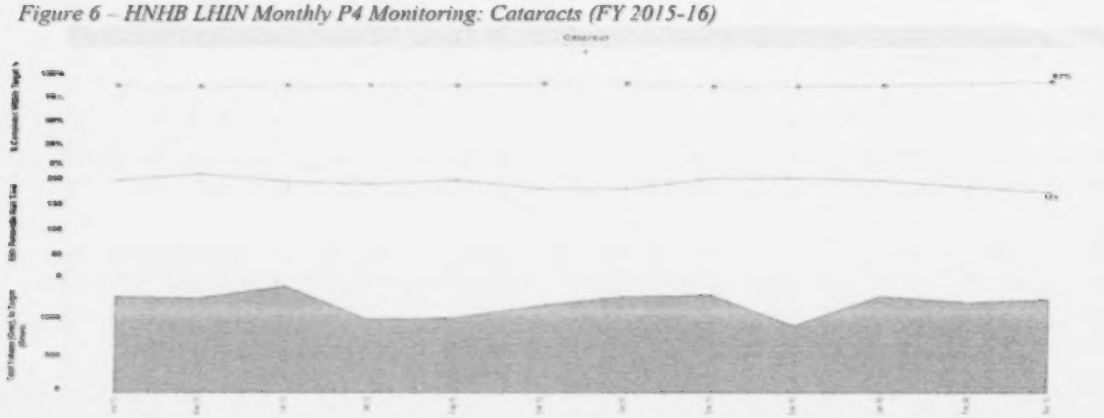


(Source: WTIS iPort Access) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

Ophthalmology

Cataract surgeons assess each patient and determine how urgent their need for treatment is, ranging from more urgent (Priority 1) to less urgent (Priority 4). In 2015-16, 16,671 cataract surgeries (priority 2-4 levels) were completed in the HNHB LHIN improving people's vision and quality of life. The LHIN reached the provincial target for P4 cases by completing 90% of those surgeries within the 182-day target for 4/12 months this year, greater than that achieved in any other prior year since 2012-13.

Figure 6 – HNHB LHIN Monthly P4 Monitoring: Cataracts (FY 2015-16)



(Source: WTIS iPort Access) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, if within 10% of the target, RED if less. Wait times are not shown when there are less than six cases in a month.

St. Joseph's Healthcare Hamilton (SJHH) served as the lead organization in 2015-16 to provide ophthalmology-specific physician and administrative leadership through the LHIN Ophthalmology

Steering Committee. The steering committee is focused on, and dedicated to, positively impacting the patient experience and has demonstrated success in the following areas:

- Prioritizing those individuals with the longest waits for cataract surgery.
- Reducing variation in patient's timely access to cataract surgery has been a focused priority at all hospitals.
- Redirecting patient referrals to surgeons with faster access to care has been able to occur for patients accepting a transfer of their care.
- Providing ongoing access to cataract surgeon's open case wait lists to facilitate physician referrals for patients to surgeons with the timeliest access to care. Improved information is available to the public, and physicians through hospital and LHIN websites and through direct, transparent communication to referring optometrists.
- Improved understanding of patient's wait times through analysis of Wait 1 (time from patient referral to consultation) and Wait 2 (time from decision to treat to surgery) was realized through utilization of the Vision Strategy Task Force Indicators now availably provincially.
- Standardizing patient prioritization coding for cataract surgery based on urgency.
- Improved understanding of hospital and physician-specific data has been achieved through engagement of surgeons and administrative leads with population needs reviewed at a zone level across the LHIN.
- The Teleophthalmology program continued to screen 242 additional patients with diabetes who were previously not receiving annual retinal screening.
- Monitoring performance for the Surgical Efficiency Target Program.
- A common referral form for cataract surgery was developed and trialed for community uptake.
- Education regarding smoking cessation strategies with the "You Can Make It Happen" program was shared with Ophthalmologists to enhance the opportunity to reduce the impact of smoking on eye health for residents of the HNHB LHIN.

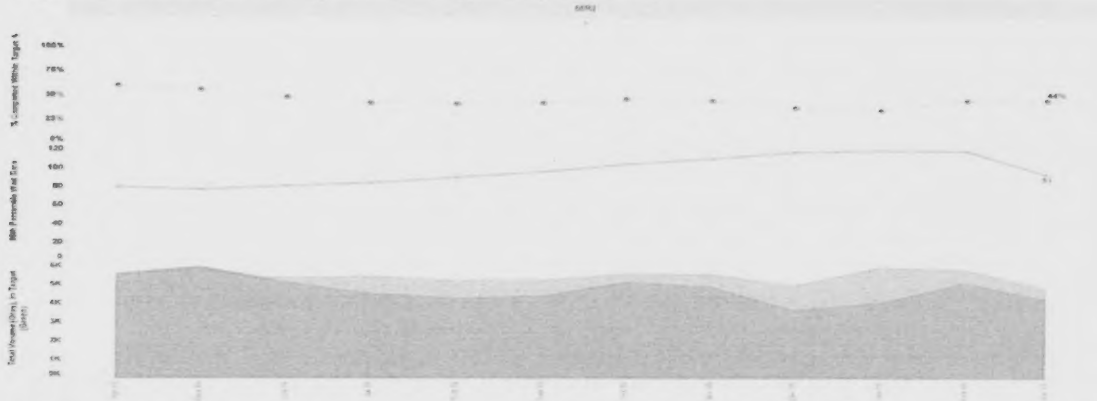
Through monthly meetings, the LHIN-wide Ophthalmology Steering Committee clinical and administrative leaders continue to share best practices, plan education for referring providers and ensure appropriate stewardship of resources in order to meet patient needs in the timeliest way possible within existing resources.

Diagnostic Imaging

In 2015-16, 64, 072 Priority 4 Magnetic Resonance Imaging (MRI) scans and 36, 965 Priority 4 Computed Tomography (CT) scans were completed within the LHIN. These are significant numbers and reflect a growing demand for these diagnostic tests. This demand has resulted in ongoing challenges to ensure patients receive the tests in a timely manner.

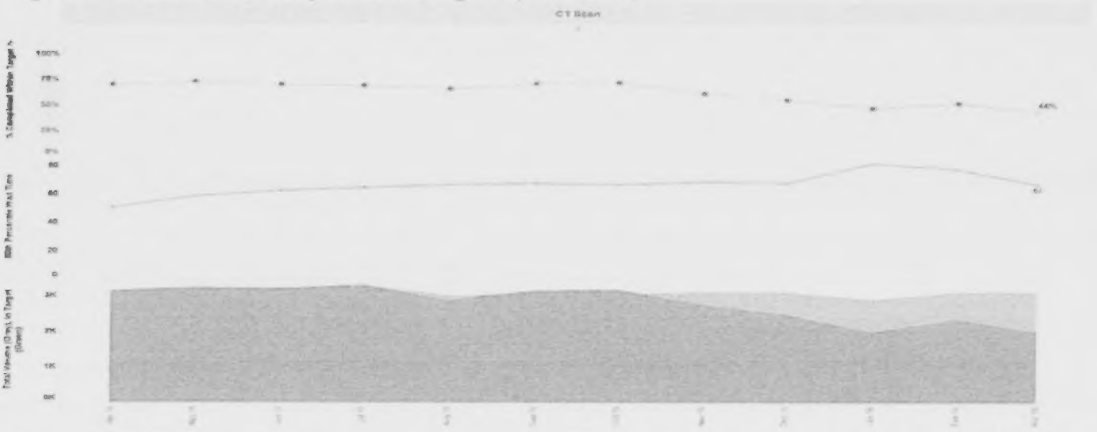
In the fourth quarter of 2015-16, 45% of combined (P2-4) MRI scans and 61% of combined CT scans were completed within the clinical wait time targets. Performance in MRI, although challenged to meet the provincial target of 90% was significantly above the provincial performance (4%) and will continue to be an area of focus for LHIN staff and the health service providers. CT performance was below the provincial target of 90%, and below provincial performance (14%). As Priority 2 and 3 patients are more medically urgent, a large focus this year has been on realigning available resources to support those patients with more medically urgent imaging needs.

Figure 7 – HNHB LHIN Monthly P4 Monitoring: MRI (FY 2015-16)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

Figure 8 – HNHB LHIN Monthly P4 Monitoring: CT (FY 2015-16)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

The LHIN-Wide Diagnostic Imaging Steering Committee, comprised of physician and administrative representation from all hospitals currently providing MRI and CT services, continued the establishment of collaborative partnerships and evidence-informed best practice sharing within and across hospitals.
The LHIN-Wide Diagnostic Imaging Steering Committee worked to positively impact patient experiences through:

- Prioritizing for those individuals with the longest waits and most medically urgent needs for scans being seen first, to reduce the variation in timely access to MRI and CT scans within the LHIN.
- Redirection of patient referrals to CT locations with faster access to care has been able to occur for patients accepting a transfer of their care amongst two collaborative facilities.
- Transparent physician access to MRI and CT scan wait times at all facilities across the HNHB LHIN has been facilitated through communication with primary care physicians.

- Development of a draft common LHIN-wide referral form for CT and MRI was initiated and is to be finalized.
- Joseph Brant Hospital has recently implemented a "Consult Radiologist" phone consultation program to trial effectiveness in ensuring appropriate ordering from both community and hospital based physicians.
- Education was provided to all Diagnostic Imaging Chiefs and Administrative Leads regarding the specific health needs of the Franco-Ontarian population.
- Hospital and LHIN specific data continues to be analyzed and has been achieved across the HNHB LHIN with the engagement of Radiologists and administrative leads at MRI and CT sites.
- Ongoing participation in Choosing Wisely Canada to discuss appropriate utilization for CT and MRI to create a culture of accountability for the ordering of tests by referring providers.
- Usage of the MRI Process Improvement Dashboard to identify facility challenges and successes continues with review by both Radiology Chiefs and Administrative Leads.
- Identification of benchmark times for common MRI scans and standardization of rapid protocols across facilities where possible was completed. Implementation will need to continue into 2016-17.
- Continued collaboration with LHIN-Wide Pediatric MRI working group to address issues unique to pediatric patients resulted in specific ministry acknowledgment of resources required (within existing resources) to support MRI scans for children requiring general anesthesia to have an MRI scan.

Evidence-based, best practice sharing and alignment, continue and will be maintained through bi-monthly meetings of the LHIN-wide Diagnostic Imaging Steering Committee, Diagnostic Imaging Directors Group, and the Diagnostic Imaging Medical Chiefs groups.

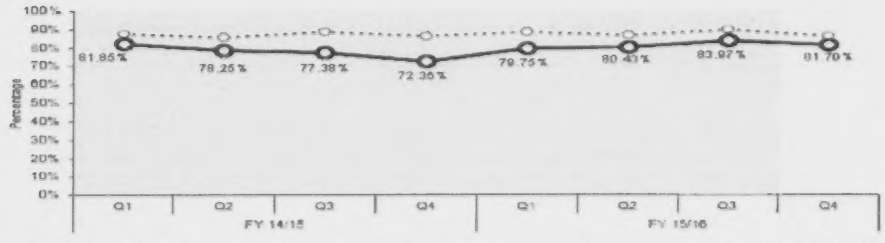
Cancer Surgery

The LHIN continued to work closely with the HNHB Regional Cancer Program and has seen overall improvement in wait times across the LHIN. Recently, Cancer Care Ontario (CCO) allocated an additional Gynecologic Oncologist and recruitment for this position has begun. The LHIN continues to remain challenged to meet prostate cancer surgery wait times due to patients choosing to wait for the less invasion capital robotic, capital surgical, and capital procedures. The LHIN and its hospitals continue to collaborate with the Regional Cancer Centre in Hamilton to look at innovative efficiencies to improve the patient experience and implement best practice across the LHIN.

Figure 9 – HNHB Quarterly Monitoring: Cancer Procedures (FY 2014-15 to 2015-16)

Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery

Summary (Q4 FY 15/16)	LHIN Performance				Provincial Performance (Combined)
	Priority 2: 14 Days	Priority 3: 28 Days	Priority 4: 84 Days	Combined	
	77.78%	78.44%	88.30%	81.70%	86.56%



(Source: WTIS iPort Access.) Notes:Quarterly wait time performance (%Within Provincial Access Target) is coded ***Solid Black*** *for HNHB LHIN performance and* ***Dashed Line*** *for provincial performance*

Laboratory Services

The HNHB LHIN Laboratory Medicine Network and Council clinically integrated into CoLabs this year - a regional laboratory system that provides consistent and standardized quality and care across all hospital laboratory sites for the benefit of our patients served.

The laboratory medical directors of Co-Labs collectively developed recommendations related to laboratory testing utilization to ensure patients are receiving the most appropriate care:

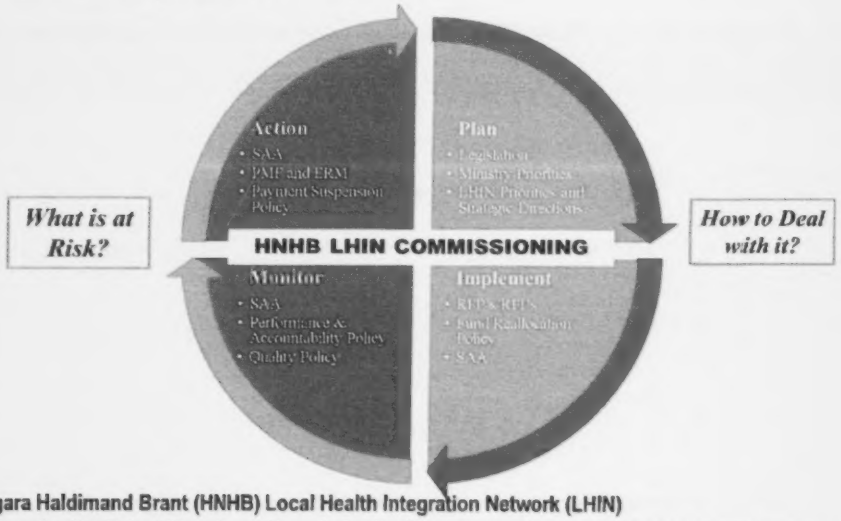
- Standardized critical value test results and reporting have been sustained across the LHIN, ensuring patient's care consistency.
- Quality improvement initiatives to reduce patient test turnaround times have continued, and quarterly reviews are used to identify potential quality issues for patient-centered care.
- Transfusion medicine planning was implemented.
- Laboratory automation continues to enhance workflow efficiencies and test turnaround times, impacting the speed of access to the most appropriate care for patients.
- Strategic planning was initiated for laboratory medicine services.
- Choosing Wisely Canada recommendations continue to be implemented across sites, reducing unnecessary testing for patients and reducing risks.

Health System Commissioners

A key strategic priority for the LHIN is to ensure accessible, patient-centered services that also reflect value for money. The LHIN maintains 187 Service Accountability Agreements (SAAs) with HSPs and monitors fiscal and operational performance. The LHIN is also responsible for working with individual providers on key system-wide priorities, including Mental Health and Addictions, emergency department (ED) wait lists, alternate level of care (ALC), and supporting home and community care.

To drive a greater focus on value, the LHIN adopted commissioning best-practices - a proven international best practice in health care management. Commissioning is a complex process with responsibilities ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the LHIN staff and Board continued to enhance health system decisions based on evidence and performance.

Figure 10 – Commissioning Model at the HNHB LHIN:



A key strategic component in the advancement of the LHIN's role in commissioning is provider engagement and the LHIN developed and implemented an engagement plan aligned with Service Accountability Agreement negotiation timelines to ensure significant performance issues are addressed at the time of agreement negotiations.

Successes in Commissioning

In accordance with Ministry Guidelines for Collaborative Home and Community-based Care Coordination, in December 2014/January 2015, the LHIN began the process of transitioning CCAC clients with low to moderate in-home personal support care needs from CCAC services to Community Support Service (CSS) agencies to provide the same services. In order to maintain the current service levels, it was important that the services provided by the CSS agencies were at the same hourly rate as the Community Care Access Centre (CCAC). LHIN-funded Assisted Living/Supportive Housing (AL/SH) CSS agencies that had been contracted to provide personal support services were invited to be a part of this new strategy. Seven of thirteen service providers indicated interest in providing Personal Support Services (PSS) at the LHIN-funded rate. Each of these providers was experienced in delivering outreach/in-home PSS and had the required capacity for data monitoring and human resources. Once the interested providers were identified, providers came together to determine which areas of the LHIN geography they were able to service. The CCAC provided a list of clients that would be transitioning and providers were assigned hours and clients based on a client's location and the geography served by the provider. Since the initial transition of clients, additional clients were added to service with the CSS agencies from the CCAC waitlist. As well, an additional group of clients has been transitioned from CCAC services to CSS services in 2015/16.

Future Opportunities

There are a number of commissioning opportunities identified in collaboration with HSPs over the last year, including:

- Leveraging funding opportunities to further enhance the LHIN health care system based on population needs and priority health outcomes;
- Further developing and evolving the use of frameworks and tools to assist in planning, allocating, monitoring and responding;
- Maximizing Health System Funding Reform (HSFR) to benefit HNHB residents – fully utilizing Quality Based Procedure (QBP) volumes and funding to HSPs; and,
- Continuing to support Mohawk Shared Services to integrate administrative support services in hospitals and develop a plan for reducing duplication in administrative support services in the community.

Advancing Health System Priorities

Mental Health and Addictions

The LHIN is committed to supporting the development of a person-centred, integrated and coordinated Mental Health and Addictions (MHA) system. Currently, services are fragmented, spread across several provincial ministries and offered in a variety of care settings. During 2015-16, the HNHB LHIN worked to address these issues to ensure people receive the best care possible.

- In their lifetime, 10-20% of HNHB LHIN residents will have a substance use disorder.
- 70% of people with mental health issues were diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

Strategic Alignment with Provincial Priorities

MHA has been identified as a priority by both the province and the LHIN. The investments made and successes achieved over the past year are aligned with the strategic pillars of the next phase of Ontario's Comprehensive Mental Health and Addiction Strategy, *Open Minds, Healthy Minds: Transforming Mental Health and Addictions Services in Ontario*:

- Promote resilience and well-being in Ontarians.
- Ensure early identification and intervention.
- Expand housing and employment supports, and diversion and transitions from the justice system.
- Provide the right care, at the right time, and in the right place.
- Fund based on quality and need.

Building Capacity to Support Individuals with Mental Health and Addictions through Regional Collaboration and Integration

A LHIN-wide Mental Health and Addictions Advisory group, supported by the leadership of St. Joseph's Healthcare Hamilton, was established in 2013 to implement integrated service delivery. In 2015-2016, the Advisory Group provided leadership for our LHIN-wide system redesign and continued to support the progression in its priority areas:

- Enhanced medical collaboration between psychiatry and primary care.
- Enhanced system performance through LHIN-wide scorecards for both hospital and community.
- Targeted priority populations including Early Intervention and Concurrent Disorders.
- Enhanced integration and collaboration through Health Links and other specific proof of concept projects.
- Enhanced services for children and youth through cross-sectoral collaboration with the Ministry of Child and Youth Services (MCYS).

Improved Access to Mental Health and Addictions Services

In 2015-16 $4.8 million in new funding was provided to programs and initiatives that support phase 2 of Ontario's Comprehensive Mental Health and Addiction Strategy. Funding was targeted for integrated initiatives including health promotion and prevention; early intervention and self-management; treatment planning, risk/crisis management and support; and, specialized care.

This new funding supported patients, families and clients through:

- Expanding existing evidence-informed training for families, caregivers and other non-health professionals across the HNHB LHIN, specifically, Mental Health First Aid, Safe Talk, Applied Suicide Intervention Skills Training [ASIST], and Talking About Mental Illness [TAMI].
- Enhance and expand early intervention services for youth ages 17 to 24, including enhancing and expanding existing Early Psychosis Intervention programs, and implementation of a LHIN-wide Mobile Outreach team.
- Integrate and reduce variation between the Mobile Crisis Rapid Response Teams (MCRRTs) and Crisis Intervention Training (CIT) with Police across the HNHB LHIN.
- Enabling a LHIN-wide Concurrent Disorders capacity building project.
- Enhance existing successful training programs for specialized therapies/interventions for health professionals, including, sustaining achieved outcomes and spreading implementation further across the HNHB LHIN, and within the three zones:
    - Dialectical Behavioural Therapy [DBT] training and supervision, and Collaborative Assessment and Management of Suicidality [CAMS] training and supervision.
    - Expand Assertive Community Treatment (ACT) team services in Niagara through the implementation of a second ACT team.

One in five persons, or 280,000 people, in the HNHB LHIN will be affected by mental illness at some point in their lives *(Source: Health Canada, A Report on Mental Illness in Canada, 2002).* Approximately 42,000 people, or 3% of people in the LHIN, are dependent on alcohol or illicit drugs in a given year *(Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008).* 30% to 54% of Ontarians diagnosed with a mental illness will also be diagnosed with another mental illness or an addiction *(Source: Making It Happen: Implementation Plan for Mental Health Reform, Ontario Ministry of Health and Long-Term Care: 1999).* The investments made over the past year aim to make a difference in the lives of these people and their families.

Maternal Child and Youth

Through collaboration with provincial forums, and local maternity and newborn providers, the HNHB LHIN works to provide consistent, standardized, equitable and evidence-informed care across the LHIN. The LHIN continued to support the work of the Provincial Council for Maternal and Child Health (PCMCH), which led a number of initiatives tackling key issues affecting the delivery of care to mothers, newborns, children and youth in Ontario, resulting in significant improvements in how care is understood, delivered and evaluated by providers.

The LHIN also continues to promote and support the work of the Southern Ontario Maternal Child Network (SOMCHN) which enables the consistent delivery of safe, quality maternal, newborn, child and youth care.

These partnerships aim to ensure appropriate and timely access to clinical services at the right level of care, along the continuum of the maternal, newborn, child, and youth health system, including access for Franco-Ontarians, and Ontario's Indigenous Peoples.

Improving Quality in Maternal Child Health Services through Regional Collaboration and Integration

The SOMCHN is a network composed of clinical leaders from maternal child programs/services from across HNHB, Waterloo-Wellington and Mississauga-Halton LHINs. SOMCHN that promotes the

regional collaboration of services and recommends integration opportunities by bringing clarity to roles and addressing gaps and redundancies in services.

The SOMCHN continues to align with the work of PCMCH to support their identify priorities for 2016-2017. Identified priorities include the development of a prenatal screen strategy, a low risk maternal and newborn strategy and a Complex Care for Kids Ontario (CCKO) strategy.

Improving Services for Children and Youth with Special Needs and Their Families

The HNHB LHIN is participating as a core partner in Ontario's Special Needs Strategy. The Strategy is aimed at ensuring children and youth with special needs have timely access to the effective services they need, and to improve the service experience of families.

The work focuses on:

- Identifying children and youth earlier and getting them the right help sooner, through the creation of a new developmental screen for children in the preschool years;
- Connecting families to the right services and supports by implementing service planning coordinators for children and youth with multiple or complex special needs; and,
- Improving access to and making supports and service delivery seamless by integrating the delivery of rehabilitation services (i.e., speech-language therapy, occupational therapy, physiotherapy).

Health and Wellness

Achieving optimal health is complicated by the complex interactions between social and economic conditions that impact individuals, communities and countries. An individual's health can be impacted by where they were born, where they live, their age, and the type of work they do for a living. These conditions create health disparities among population groups.

Health Quality Ontario (HQO) defines health equity as the ability for an individual to achieve "their full health potential, and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have, or who they are."

The LHIN is committed to addressing these health disparities within the context of the health care system by incorporating a population health approach and health equity lens into planning, funding, and the integration of health services.

Addressing Health Equity in the HNHB LHIN

In September 2015, the HNHB LHIN formed the Health Equity Action Plan (HEAP) Working Group to support it in its efforts to improve population health outcomes by eliminating health inequities and barriers to accessing health services, and improving patient experience and healthcare outcomes. The HEAP Working Group will collaborate with the LHIN to advise on health equity priorities and to assist in the development of an annual health equity action plan.

Opportunities to integrate equity into the work of the LHIN include:

- Identifying vulnerable or marginalized populations
- Understanding the population and local needs
- Considering the impact of the social determinants of health and how they intersect

- Identifying mitigation strategies
- Monitoring and evaluating process and outcome measures

In addition to its priority populations (Indigenous Peoples and Francophone populations), the LHIN identified three vulnerable or marginalized populations to focus on for 2015-16: Migrant Agricultural Workers (MAWs), newcomers, and homeless individuals.

Through the work of the HEAP Working Group, the LHIN looks to broaden the application of a health equity lens to include other identified population groups across the LHIN in alignment with provincial priorities in *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

The activities of the HEAP Working Group is guided by the HNHB LHIN's Health Equity Planning Framework that was adopted in 2014. Continued planning and development of the action plan will ensure alignment with the ministry, provincial priorities, HQO and shared LHIN initiatives.

Addressing Health Disparities in Target Populations

The LHIN continues to implement the health equity planning framework to guide its approach to addressing the social determinants of health and to achieve health equity in its planning activities. In 2015-2016 the LHIN identified two of the three target populations to focus on:

- Migrant Agricultural Workers
- Newcomers

Migrant Agricultural Workers

Each year, more than 38,000 legal temporary contract positions are available in Canada for migrant workers. Industry within the HNHB LHIN employs up to 8,000 workers. While migrant agricultural workers are covered by Ontario Health Insurance Program (OHIP), the vast majority do not access health care services, but those who do typically seek urgent health care through walk-in clinics or EDs.

The most common health conditions with which migrant agricultural workers present include injury / trauma, gastrointestinal, musculoskeletal, eye, skin, respiratory, and urinary problems. There are a number of practical and systemic barriers to the workers accessing traditional health care/primary care services including:

- Fear of being sent home by their employer or not invited back the following year;
- Lack of awareness of available primary care services and how to access them;
- Inability or reluctance to take time off work;
- Lack of access to a health card; and/or,
- Lack of transportation from their area of work to where services exist.

In 2014-15, the LHIN funded three primary health clinics serving the communities of Delhi, Simcoe and Virgil in partnership with Grand River Community Health Centre in Brantford and Quest Community Health Centre in St. Catharines. The primary care-based model is Nurse Practitioner-led and supported by a team of professionals including a Registered Nurse, an outreach worker, a translator, and volunteers.

In 2015-2016, based on demonstrated success, the LHIN enhanced funding to expand to three more sites in Hagersville, Brantford and Vineland. Together these sites have seen a total of 1028 clients.

Newcomers

The Peace Bridge in Fort Erie, Ontario is Canada's highest-volume entry point for refugees seeking asylum in Canada. Since 2000, an average of more than 5,000 refugees per year have entered the country at Fort Erie, and this number has increased significantly in the past 15 years. An estimated 15 to 25% of refugees entering Canada at Fort Erie remain in the Niagara Region. Refugees arriving in Canada experience multiple challenges which negatively affect almost all social determinants of health, and they are widely recognized as among the most marginalized members of society, with poorer health, greater health needs, and more significant access barriers than immigrants and Canadian-born citizens.

In September 2015, Ontario committed to collaborating with the Government of Canada and other partners to support the permanent resettlement and integration of approximately 10,000 Syrian refugees. In March 2016 the HNHB LHIN welcomed nearly 1,000 Government Assisted Refugees with the leadership of Wesley Urban Ministries and the support of the LHIN's many dedicated health care providers and partners. The health sector responded by providing initial health assessments, immunizations, and ensuring a warm transfer to primary care services.

As health is an important component of transition planning, the LHIN will continue to support the delivery of health care services to all newcomers and will work with the Health Equity Action Plan Working Group to develop a targeted approach to improving newcomer health.

Population Health and Wellness

The LHIN has also committed to partnering with local Public Health Units (PHUs) to incorporate a population health perspective to the assessment of community needs, and the planning and integration of health services. The HNHB LHIN will be working with PHUs to identify areas for coordination and collaboration in strategic planning to improve population health and wellness. In 2015-2016, the LHINs identified smoking cessation as an initial and immediate opportunity to build a collaborative relationship with local PHUs.

Smoking is the primary cause of premature and avoidable death and disease in Ontario. In Canada, tobacco-attributed deaths account for approximately 17% of all deaths. In Ontario, this amounts to over 13,000 Ontarians who die each year as a result of tobacco use. Tobacco use also poses a significant economic burden in direct costs to health care and indirect costs such as productivity loss. Recognizing there are wide regional variances in the rate of smoking, the HNHB LHIN has the highest prevalence of smoking at 23.8%; compared to that of Ontario at 18.1%

The HNHB LHIN partnered with the Central West Tobacco Control Area Network and local PHUs to help endorse the "You Can Make It Happen" campaign which offers a comprehensive source of information, tools and resources about tobacco cessation for healthcare providers. The campaign supports the use of the 5A model (Ask, Advise, Assess, Assist, Arrange) which offers a simple framework for minimal contact tobacco intervention that healthcare providers can integrate into daily practice to ensure that for every patient, at every visit, tobacco use status is queried and documented. The HNHB LHIN will continue to assist in increasing the number of healthcare providers implementing the 5A model.

Prevention and Management of Chronic Conditions

Optimizing wellness through the prevention and management of chronic conditions continued to be a priority for the HNHB LHIN.

Despite Canadians having access to more health information than ever before, the number of Canadians with chronic conditions continues to increase, especially in the 35-74 age category. The Public Health Agency of Canada estimates that three out of five Canadians have a chronic disease and four out of five are at risk of developing a chronic disease *(Source Public Health Agency of Canada: Preventing Chronic Disease Strategic Plan 2013-16).* In Ontario, chronic diseases, including cancers, cardiovascular diseases, chronic respiratory disease and diabetes were responsible for 79% of all deaths in the province in 2007. The chronic disease burden is experienced inequitably among some populations such as Indigenous peoples and individuals living in poverty *(Source: Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario, Cancer Care Ontario & Public Health Ontario, 2012).*

Advances in medical science and technology mean that Ontarians are living longer and are therefore more likely to develop chronic disease as they age. However, Ontarians are also living differently than generations ago. There are strong associations between the most common chronic diseases and risk factors like tobacco and alcohol consumption, physical inactivity and unhealthy eating. In the 2013 Canadian Community Health Survey, HNHB LHIN residents reported higher rates of chronic conditions such as chronic obstructive pulmonary disease (COPD), arthritis, hypertension, diabetes, asthma and cancer than the province as a whole. In addition, the HNHB LHIN has a higher rate of daily smoking and heavy drinking than the provincial average *(Source: Canadian Community Health Survey, 2013).*

Through 2015-16, the HNHB LHIN continued to work in partnership with HSPs to develop and implement population-based strategies that focused on specific populations to optimize, maintain or improve their health by providing a coordinated and integrated approach to health service delivery.

Diabetes

In 2013-14, the HNHB LHIN assumed the funding and accountability for eight adult and four pediatric Diabetes Education Programs (DEPs) as well as the overall coordination of diabetes services across the LHIN.

Diabetes in the HNHB LHIN
As of April 2015, the HNHB LHIN was home to 143,317 adults living with diabetes. This is the 3rd highest population compared to all other LHINs and represents 12.1% of the HNHB LHIN adult population.
(Source: Diabetes System Indicators, 2016)

In 2015-2016, the LHIN focused on collaboration and partnerships between HSPs, including primary care, with the goal to improve access and coordination of services for people living with diabetes. The LHIN's annual work plan included a number of initiatives that required innovative partnerships. A key enabler to advance these initiatives is the committed leadership demonstrated by the members to the LHIN's two Leaders in Diabetes Committees, one focused on the adult and on the pediatric population diabetes. These committees include representatives from all DEPs, including both ministry and LHIN-funded programs. Key 2015-16 priorities included:

Adult Population

- Improved access to DEPs through standardized referral processes:
  - A LHIN-wide three zone coordinated access model for DEPs and standardized LHIN-wide DEP referral form was developed and implemented in consultation with Primary Care and all LHIN and ministry funded DEPs. Within this model there is "no wrong door" for access to DEPs.
  - Introduced a self-referral process for DEP programs; 524 individuals had accessed a DEP program through self-referral as of December 31, 2015.
- Improved utilization of Adult LHIN-funded DEPs:
  - LHIN DEPs reported seeing 14,536 clients as of December 31, 2015, compared to 18,431 for the full fiscal year of 2014-15 (April 2014– March 2015). Overall, the LHIN was on track to achieve a 3.4% increase in client volumes.
- Improved access to specialized services for DEP clients through partnerships and innovations:
  - Partnership between Six Nations DEP and Hamilton Health Sciences (HHS) to support complex clinical consultations, knowledge transfer and capacity building with the advanced DEP team (Nurse Practitioner, Clinical Nurse Specialist, and Advanced Dietitian) via Ontario Telemedicine Network (OTN)
  - Direct referral partnership between Six Nations DEP and St. Joseph's Healthcare Hamilton (SJHH) Nephrology Program for Six Nations DEP clients with mild to moderate kidney disease without a primary care provider
  - Improved access to diabetic wound care for DEP clients via telemedicine pilot project - HNHB CCAC wound care consultants facilitated 210 telemedicine wound care visits for patients in Niagara, Ohsweken and Norfolk with foot ulcers, vascular leg ulcers and other wounds between November 2015 and February 2016 (Source: CCAC/CarePartners Diabetic Foot Ulcers Telemedicine Pilot Presentation, March 2016). The project has also enhanced knowledge and accountability for wound care management for frontline nursing staff. Next steps include further data analysis and program expansion.
  - "Team Fridays" in partnership with Southern Ontario Aboriginal Diabetes Initiative (SOADI). A day where individuals with or at risk of diabetes can access services without an appointment. The team consists of an Aboriginal Patient Navigator, elders, a dietitian, a Nurse Practitioner, and a DEP team member. Individuals can access any type of service or program through the day at their convenience including planned activities like yoga and a healthy lunch. Eye screening through OTN is also offered every six weeks.

Pediatric Population

- The LHIN established a Pediatric Diabetes Leaders Committee comprised of representatives from all Paediatric DEPs (PDEPs) to improve the coordination and delivery of pediatric diabetes services and implement a new standardized reporting methodology for PDEPs for 2015-16.
- The LHIN's four PDEPs served 812 pediatric clients for a total of 6,342 clinical interactions as of December 31, 2015.
- Key priorities for the Pediatric Diabetes Leaders Committee for 2016-17 include:
  - Improving access to timely and appropriate specialized pediatric diabetes care for children and youth through standardization of processes for accessing higher levels of pediatric care.
  - Working with Adult DEPs to implement provincial recommendations regarding effective transitions of youth from pediatric to adult care. The goal is to support high-quality, developmentally appropriate, psychologically sound care that is continuous, comprehensive, client-centered and coordinated, before and throughout a youth's transition from the pediatric to the adult system.
  - Implementing provincial recommendations for improved access and coordination of mental health and psychosocial services for youth living with diabetes and their families.

The intent of these recommendations is to promote a more streamlined process for pediatric diabetes clients seeking mental health and psychosocial supports.

Stroke

Integrated Stroke Recovery System

In 2015-16, the HNHB LHIN continued to work with providers to integrate stroke care. The Ontario Stroke Network (OSN) annual report card demonstrated improvements in eight indicators from the previous report card (Source: Ontario Stroke Network Report Card 2013-14). Niagara Health System Greater Niagara General Hospital site is the top performer to administer the clot-busting medication tPA (Tissue Plasminogen Activator) for eligible individual people with a diagnosis of stroke (Source: Ontario Stroke Network Report Card 2013-14).

> Persons post stroke who receive their care on a dedicated stroke unit by a dedicated interprofessional team are more likely to be alive, independent, and living at home one year post stroke.
> *(Source: Stroke Unit Trialists' Collaboration. Organized inpatient (stroke unit) care for stroke. Cochrane Database of Systematic Reviews 2007, Issue 4. Canadian Best Practice Guidelines for Stroke) Care, 2010).*

In May 2015, the Ontario Stroke Network released its report care for 2013-14, which reported increased access to acute stroke unit care (34.3% to 43.6%) in the HNHB LHIN. This reflected the new integrated Stroke Unit (ISU) opened at Brant Community Healthcare System (BCHS) June 2013. This model improved access to acute stroke unit care in the HNHB LHIN. The opening of the ISU has also resulted in an increase in the proportion of patients discharged to inpatient rehabilitation from 33.5% to 36.4% in the HNHB LHIN *(Source: Ontario Stroke Network Report Card 2013-14).*

*Figure 11: Community Stroke Rehabilitation Model Outcomes**

Regardless of stroke severity individuals:	
Met their goals	90%
Demonstrated functional recovery	+5% (mild) +20% (moderate) +18% (severe)
Demonstrated improved reintegration to normal living	+39%
Received timely access	3.3 days
Received intensive best practice community stroke rehab	32 visits
Were satisfied	87%
Received care from a consistent, expert stroke team	90%
Overall there was a potential cost avoidance for the stroke system	$564.95 pp

**based on the results of 31 individuals*

Following implementation of an integrated stroke recovery system in BHN, access to stroke unit care and community stroke rehabilitation improved in BHN from:

- 0% of individuals receiving ISU care at BCHS prior to the launch to 84.5% of individuals treated on an ISU post launch (Source: BCHS Q2 2015-16 site-specific results).
- Zero individuals receiving best practice intensive community stroke rehabilitation in the home to 80 individuals accessing a CSRM (Source: HNHB CCAC Q2 2015-16 report).

Community Stroke Rehabilitation Model

An evaluation of the Community Stroke Rehabilitation Model (CSRM) to determine applicability to other LHIN areas and populations was completed. The model provides access to best practice in-home community rehabilitative stroke care for individuals who live beyond 30 minutes of an outpatient therapy centre and/or do not have the tolerance to travel. Prior to the launch of the model, individuals received an average of 4.1 therapy visits, much less than recommended best practice. Following the launch of the CSRM, individuals receive an average of 32 visits based on need. The evaluation indicates that regardless of stroke severity, individuals met their goals, demonstrated functional recovery and improved integration to normal living. Care was delivered in a timely way from a consistent expert stroke team providing intensive best practice stroke care.

Overall, there was a decreasing trend in hospital stay, with an average decrease of 6.6 days per person with the launch of the ISU and the CSRM resulting in an overall potential cost avoidance of $564.95 per person (see Figure 11).

The results of the CSRM have been shared at the National Stroke Congress in Toronto as well as at Ontario Stroke Network forums in London and Hamilton. The results have been determined to be applicable to other areas of the HNHB LHIN and other LHINs.

COPD and CHF

Chronic Obstructive Pulmonary Disease (COPD) is a chronic, progressive respiratory condition that is often caused by smoking. Congestive Heart Failure (CHF) is a weakness of the heart that can lead to shortness of breath, excessive tiredness and leg swelling. Both COPD and CHF are chronic and progressive conditions and, as a result, are the two most common reasons for hospital readmissions in the HNHB LHIN.

A LHIN-wide integrated model of care for individuals with COPD that is community-based called "Caring for my COPD" was implemented at four main sites in 2014. In 2015-16, this program began offering outreach sites in areas with an identified high level of need such as Norfolk. Additionally, sites were able to offer improved transportation support for clients to attend the program. As of December 31, 2015, a total of 362 individuals accessed this program in 2015-16.

Additionally, the HNHB Integrated Comprehensive Care Program (ICCP) is being implemented across all HNHB LHIN acute care hospital sites for hospitalized patients with a diagnosis of COPD and/or CHF who will be discharged home. These patients will be supported by a care team and receive home care for up to 60 days post hospital discharge.

Key features of the program include integrated care coordinators to develop and manage personalized action plans, standardized care pathways, timely access to medical expertise, and 24/7 availability of a care team member. Refer to the Home and Community Care section on Page 52 for more information on this model of care.

Older Adults (including caregivers and families)

The LHIN's population, similar to Ontario's and other jurisdictions', is aging. In 2015, more than 260,000 people age 65 or older lived in the HNHB LHIN. This number is projected to increase to 360,000 by 2025, with the greatest growth occurring in the population aged 75 years and older *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long Term Care, IntelliHEALTH Ontario)*. In addition to managing their own health issues, older adults may fulfill a caregiver role for their spouse or another family member.

In 2015-16 HNHB LHIN activities have focused on initiatives that:

- Prevent functional and cognitive decline – through increasing access to exercise and wellness programs
- Maintain and restore functional and cognitive ability
- Support informal caregivers.

Exercise and Falls Prevention

Healthy Active Seniors

Fall-related injuries represent a significant health concern among individuals over the age of 65 and are particularly concerning for individuals living independently at home in the community *(Source: Public Health Agency of Canada (2014). Seniors' Falls in Canada: Second Report)*. Individuals experiencing a fall often suffer from devastating physical and psychological injuries which negatively impact quality of life and activities of daily living. Research has shown that progressive, tailored exercise programs contribute to improvements in strength, gait, and balance, as well as offer a chance for seniors to socialize and become more educated about key risk factors for falls. However, Statistics Canada estimates that only 11% of seniors between the age of 65 and 79 meet Canada's physical activity guideline *(Source: Public Health Agency of Canada (2014). Seniors' Falls in Canada: Second Report.)*.

During April 2015 to December 2015, the LHIN provided Falls Prevention and Exercise classes to 7,675 individuals across 209 locations throughout the region.

In December 2015 and January 2016, the LHIN visited 15 community exercise classes to hear from participants about their experiences in the program. Over 40 participants shared stories of improved physical, mental, and emotional well-being demonstrating the value and impact this program has had in the community.

Keeping Active – What the clients told us

"I have had back trouble and arthritis in my joins. Since joining the program I am getting so much more mobility. I could never afford this type of program at a gym as a senior on a fixed income."
Stay Well Program, St.Joseph's Healthcare Hamilton

"Before these classes I couldn't move anything. Now I can move my body parts and my back feels so much better. It gave me my life back. I am 86 but now I feel like 17…I smile all the time."
Stay Well Program, St.Joseph's Healthcare Hamilton

"Seniors, some who are alone, do not have much of a social life. This gives them a reason to get out and meet other people."
S.A.F.E. Zone Program – Adult Recreation Therapy Centre

"I have suffered for years with chronic neck/shoulder pain and have tried massages, physiotherapy and chiropractor; but honestly, I have found better, long-lasting relief from taking these classes."
Ready, Steady, GO! – St.Williams Community

Seniors Mobile Assess Restore Teams (SMART)

As of April 1, 2015, a two-year Seniors Mobile Assess Restore Team (SMART) model was implemented across six hospital sites, with the goal of improving and preventing further functional decline in high-risk seniors. According to the literature, "for every day an older person spends lying in bed (or waiting on a stretcher in the emergency department) it takes two days to recover" *(Source: Kaira, 1994; Mehta, 2010).*

Figure 12: SMART Evaluation Results

Deliverables	Outputs and Outcomes
• Improves Quality of Care • Increases capacity • Prevents functional decline • Improves functional independence	• 2278 individuals served1 • 20% increase in function (Barthel)2 • 87% discharged Home1
1. Integrated Services 2. Eliminates transition points, associated referrals, assessments and wait times	3. 20% decrease in the number of ALC days for patients discharged to Complex Care-Low Tolerance Long Duration
• Adds Value • Decreases need for bedded post-acute bedded rehabilitative care • Decreases LOS in bedded post-acute rehabilitative care • Cost avoidance	• 87% of individuals avoiding post-acute bedded rehab1 • Decrease in acute ALC LOS for individuals waiting for bedded post-acute rehab care3

Sources: 1. Hospital SMART quarterly reports (6 sites) 2. Hospital SMART quarterly reports (2 sites) 3. HNHB LHIN level data. Access to care iPort 5, 538 ALC days for 9 month period April 1, 2015 to December 31, 2015 compared to the same 9 month period prior to SMART 6,893 ALC days between April 1, 2014 to December 31, 2014 for the 6 hospital sites involved with SMART)

The SMART model was evaluated for its impact on length of stay (LOS), ALC designation/ALC days and the need for restorative programs for specific populations. The evaluation of SMART indicates that the program:

- Improves quality of care through the prevention of functional decline and improvement of functional independence.
- Integrates services - eliminates transition points by providing restorative care in the emergency department and acute medical wards in parallel with acute care.
- Demonstrates added value. The majority of individuals are discharged home directly from acute care, however, individuals who require post-acute rehabilitative care within hospital have a considerably shorter length of stay. Refer to evaluation results in Figure 12.

SMART

"Thank you, thank you, thank you all. My mother was recently discharged to her HOME as a result of the tremendous care and compassion she received through the SMART program at the Brantford General Hospital.

What a fantastic program, I hope it will always be a part of the hospital's therapy services. Our family is very grateful to you all. Mother was very fond of Karla and Kara and send her love and thanks to you all! A very grateful family!"

-Family member of SMART program participant

An HNHB LHIN SMART evaluation logic model was developed to inform the evaluation. The HNHB LHIN leads a Pan-LHIN Assess Restore Enhanced Service Delivery group where a pan-LHIN evaluation logic model was also developed. These logic models were used to inform a provincial pan-LHIN logic model developed by the Rehabilitative Care Alliance (RCA) to reflect assess and restore initiatives across all 14 LHINs.

Restorative Programs

The HNHB LHIN has restorative bedded programs across the LHIN to support people to regain their optimal functional status following an acute illness. These programs may be referred to as Assess and Restore, Slow Stream Rehabilitative or Convalescent Care programs and are located in hospitals and long-term care homes. Together these programs total 193 beds (increasing to 199 beds in 2016-17). While the majority of these 199 beds (164) are funding by the HNHB LHIN, 35 receive funding directly from the Ministry of Health and Long Term Care (35).

People are usually admitted from the hospital following an acute event, however, individuals can also be admitted directly from the community. The healthcare team associated with these programs may include nurses, physiotherapists, occupational therapists, recreational therapists, pharmacists and case managers from the CCAC. People admitted to the program work with the healthcare team over a period of time to regain their strength to enable them to return home. In 2015-16, 81% of the people admitted to the LHIN's Assess Restore (AR) and Slow Stream Restorative programs were discharged home *(Source: HNHB LHIN report Q3 2015-16- all sites).*

In 2015-16, the HNHB LHIN expanded access to convalescent care beds for residents of Niagara-on-the - Lake and the surrounding area. Pleasant Manor LTCH was approved to operate a 12-bed convalescent program. This program was developed in partnership with Niagara Health System. As of March 31, 2016, six of the 12 beds were operational with plans to continue to expand to the full complement of 12 convalescent care beds in 2016-17. In 2015-16, a consistent referral and information package for Convalescent Care was implemented across all Convalescent Care provider sites in the HNHB LHIN.

Rehabilitative Care Alliance (RCA)

The Rehabilitative Care Alliance (RCA) is a provincial collaborative that was established by Ontario's 14 LHINs in April 2013. With an initial two-year mandate, the RCA was established to effect positive changes in rehabilitative care through a focus on supporting improved patient experiences and enhancing the adoption and effectiveness of clinical and fiscal priorities, this included development and adoption of standard definitions. In 2015-16, a renewed two-year mandate was approved by the 14 LHIN CEOs. In September 2015, the HNHB LHIN established a local HNHB RCA network to implement the provincial standard definitions for rehabilitative care. The purpose of adopting standard definitions for rehabilitative care across the province is to increase the understanding of patients, family members and referring partners related to the population served and services available within rehabilitative care.

Since September 2015, 72 rehabilitative care providers in the HNHB LHIN have completed a mapping tool to assess the current rehabilitative care programs against the standard definitions for rehabilitative care developed by the RCA. Areas of misalignment/challenges and opportunities to support alignment with the new definitions were identified. The Provincial RCA is currently compiling the information collected from all 14 LHINs to identify common areas of alignment and misalignments across the province and within LHINs. The HNHB LHIN has developed a local RCA governance structure that aligns with the provincial RCA governance structure. An HNHB LHIN RCA advisory group will liaise with sub-region working groups to facilitate the implementation of the standard definitions as well as the completion of the RCA capacity planning framework.

The HNHB LHIN restorative programs were evaluated against the ministry AR Guideline as well as the new standard definitions for rehabilitative care. The LHIN restorative programs align with the new "activation/restoration" standard definition of rehabilitative care. The RCA has completed a "crosswalk" to demonstrate the alignment between the RCA standard definitions for bedded rehabilitative care and the types of restorative care outlined in the MOHLTC AR guideline. The provincial alignment work will inform the ongoing work to standardize definitions and capacity planning for rehabilitative care.

Supporting Family/Informal Caregivers

Numerous reports speak to Ontario's aging population and the essential role informal caregivers play in the provision of home care services as well as the stress informal caregivers can experience caring for spouses, family members and others. Caring for a family member or others can be a very fulfilling and rewarding experience; however, it can also be challenging and can cause some caregivers to experience physical, emotional, financial or social distress or burden *(Source HNHB LHIN Adult Day Program and Respite Review Working Group Findings and Recommendations. December 2014).* Health Quality Ontario reported that 97% of home care patients receive support from an informal caregiver *(Source: Health Quality Ontario. Measuring Up, 2015).* The prevalence of dementia in the HNHB LHIN is increasing, and literature reports that caregivers providing care to persons with moderate to severe cognitive impairment are more likely to report physical, emotional, financial or social distress *(Source: Sinha, S. K. Living Longer Living Well. MOHLTC. December 2012).*

In 2015, the ministry released the Action Plan for Health Care and a Roadmap to Strengthen Home and Community Care. Both of these outline system priorities of integration, consistency, capacity, quality and value. In 2015-16, the HNHB LHIN supported activities that align with the Minister's direction to strengthen home and community care by putting clients and caregivers first and improving client and caregiver experience including:

- Collaborating with LHIN-funded community respite providers to streamline and coordinate access to, and support caregivers' knowledge of, respite services that are available to them and the individuals they care for. Respite services provide caregivers with periods of relief from their caregiving duties.
- Providing a two-year approval to Long-Term Care Homes that offer access to overnight respite services. This supported families/caregivers in planning respite care (e.g. vacations).
- Supporting a Self-Care for the Caregiver program through the Alzheimer Society of Brant, Haldimand, Norfolk, Hamilton and Halton. The program provides caregivers with the opportunity to learn how to prioritize and balance their own self-care needs with those of others in their care. This enables caregivers to develop the capacity to enhance their overall health and wellbeing so that they can continue to support individuals with dementia at home.

Hospice Palliative Care

Palliative care continued to be a priority for the HNHB LHIN in 2015-16. Activities align with the ministry's Roadmap and the Declaration of Partnership and Commitment to Action Report (December 2011). Key HNHB areas of focus in 2015-16 aim to:

- Promote early identification of person with palliative care needs
- Improve communication and information sharing
- Increase knowledge of palliative care services and advanced care planning
- Develop a local palliative care system that provides patients with greater choice for palliative and end of life care

The HNHB Hospice Palliative Care Regional Council (Council) continued to work on its three-year work plan in 2015-16. Three work groups established to advance key priorities reported the following progress:

- Early Identification Working Group: As of March 2016 ten family physicians representing two family health teams and three practice sites have agreed to participate as 'early adopter' sites for the Early Identification Project.
- Regional Education Plan Working Group: Regional Education Plan completed March 2016 with a focus on Primary and Community Care.
- The Performance and Quality Measurement and Reporting Working Group: Work has been completed in refining the definitions for reporting on palliative care clients. A new reporting tool will be implemented in 2016.

> "I have been involved in helping to organize programs in hospice palliative care for the Norfolk area since 1994 and I am very optimistic about the enthusiasm and support of the LHIN in recognizing the need for end of life care"
>
> *– Norfolk Resident*

The Council also developed a stakeholder engagement strategy, as of December 2015, 18 group meetings/presentations have been provided. In addition, the HNHB CCAC hosted two Palliative Care Collaborative Planning sessions to support the development of a strategic plan that aligns with the HNHB Regional HPC Program goals.

The LHIN continues to support patients to receive hospice palliative care in the community, hospitals and LTCH settings. The LHIN supports five Residential Hospices for a total of 42 beds through funding provided to the HNHB CCAC for personal support and professional (nursing) services. The LHIN also supports Good Shepherd Centre Hamilton's Emmanuel House, a 10 bed assisted living program that provides residential hospice palliative care services. As of November 2015, 562 individuals have received care at the residential programs *(Source: HNHB CCAC HNHB LHIN Hospice Data April to November 2015. CHRIS Database).*

Advanced Care Planning
96.4% of long-term care homes completed a survey in 2015 relating to Advanced Care Planning, reporting that 99% of homes review the advanced care plan with the resident or substitute decision maker with any change in condition.

Palliative Shared Care Outreach Teams

Palliative Shared Care Outreach Teams are interdisciplinary teams consisting of clinical navigators, palliative care physicians, clinical nurse specialists, nurse practitioners, bereavement counselors, and psychospiritual counselors. These teams are located across the LHIN in Brant, Burlington, Haldimand, Norfolk, Six Nations, Hamilton, and Niagara and work with clients to meet their palliative care needs within their homes while supporting their caregiver/family. As of February 2016, the teams have seen 2,716 individuals.

Behavioural Supports Ontario (BSO) Strategy

The Behavioural Supports Ontario (BSO) Strategy is built on a framework of principles guiding the development of quality health services for people with responsive behaviours. The statement developed by LHIN providers as represented by the voice of the individuals with cognitive impairment continues to drive the LHIN's BSO activities.

"I am who I am, so help me to continue to be me"

In 2015-16 BSO programs, spanning all sectors of care, continued with a focus to improve the support for the person, family member, and health care provider as they transition across the health care continuum.

- BSO Connect – A single point of information and referral for clients, caregivers, and healthcare providers, pulling services toward clients. Connect is operated by the HNHB CCAC.
- BSO Community Outreach Team (COT) – Five teams with geriatric expertise embedded within existing community crisis teams providing 'just in time' support to individuals with, or at risk of, developing responsive behaviours and linking them to longer term support.
- Integrated Community Lead (ICL) Service Model – One community agency is the single point of contact for BSO clients. This 'approach to care' has been adopted by 41 LHIN-funded community support service agencies who provide care to the BSO community population.
- BSO Long-Term Care (LTC) Mobile Team – Five multi-disciplinary teams, serving the LHIN's 85 long-term care homes.

New to the BSO Strategy in 2015-16 was the BSO Hospital Clinical Lead positions. Two BSO Clinical Leads, employed by two host hospital organizations, Niagara Health System and Hamilton Health Sciences, were implemented in April 2015 in a staged approach across the HNHB LHIN hospital organizations.

This new addition to the BSO programs ensured individuals with cognitive impairment and responsive behaviours receive behavioural expertise and support in any care setting they may reside, including acute care settings. Core functions of the Clinical Leads include collaborating with hospital staff in the development of behavioural care plans, transition plans, and capacity building.

Supporting informal caregivers in need
"Thanks for listening and being patient with me…I am so happy that someone will come out to see this poor man who is fading away every day."
Neighbor of BSO Connect and BSO COT client

BSO 2015-16 Key Successes

BSO Connect

- 1,072 clients served as of December 31, 2015 (3,622 since April 2012)
- 100% of caregivers/clients connected to service/support after calling BSO Connect
- 62.4% of those clients had no prior services before calling BSO Connect.

BSO Community Outreach Teams

- 957 clients received crisis support as of December 31, 2015 (3,957 since program implementation April 1, 2012).
- 58% to 79% of clients were discharged with longer-term community supports in place to prevent a future crisis (based on % range for five LHIN regions).

BSO LTC Mobile Team

- 2,139 clients served as of December 31, 2015 (7,949 since April 1, 2012) with 29,506 direct client and family based services/interactions
- 1231 clients were supported through transitions to/from LTC, Community, Acute Care, and/or Tertiary Care settings as of December 31, 2015, and transition referrals have increased to become the main reason for referral to the LTC Mobile team (59.42% of referrals).
- Despite an increase in referrals year over year, there is no increase in wait times: response time between receipt of referral and first contact was an average of 0.3 days; response time between receipt of referral and a first visit was completed within 2.4 days and 2.8 days for episodic and transition support.
- 11.2% of referrals received were re-referrals to the BSO program. Of these re-referrals, 92% were for clients initially referred for episodic support, and 8% were for clients initially referred for proactive transition support.

Building Capacity Through Coaching and Modeling

"The care we have been able to offer residents and their families has grown and developed with the LTC Mobile Team's ideas and interventions"

Cathy Luke, Director of Care, Grace Villa LTC

BSO Hospital Clinical Leaders

- 187 clients served in hospitals as of December 31, 2015, by two Clinical Leaders since receiving referrals in May 2015
    - 152 clients discharged from hospital, primarily to transitional beds, LTC beds, retirement home and private homes
    - 9 patients were diverted from Behavioural Assessment Units and placed into LTC Homes.
    - Alternate Level of Care length of stay for patients in all HNHB Hospitals identified in ALC-IS data as Specialized Care Needs - Behavioural decreased from average 43.64 days/patient to 28.91 days/patient when comparing May to December 2014-15 to May to December 2015-16 when BSO Clinical Leads were implemented.

(Source for all BSO data: HNHB Strategic Lead Office)

Supporting Families in Hospital

"She made sure the team knew how to work with him and care for him…she was experienced with people like him…the hospital was not the place for my father-in-law… Thank goodness for the BSO Clinical Leader."

Daughter-in-law of hospital patient

Integrated Community Lead (ICL) Model

- Completed two additional ICL Community Partner Forums in Niagara and Hamilton in response to the demand for more ICL events promoting collaborative working partnerships across various community service providers sharing complex, older adult clients with cognitive impairment. 85 front-line staff and managers, including Health Link partners, attended these two events, resulting in a total of approximately 300 community staff and managers participating in ICL events over the last two years.
- Haldimand-Norfolk ICL Hub table partnered with Emergency Services and community leaders to

implement a communication tool, "Vial of Life", for service providers and emergency responders to utilize when serving clients in their homes and share with emergency departments(ED) if presenting to ED.

Advancing eHealth in the HNHB LHIN

The Health Information Technology Services (HITS) eHealth Office at Hamilton Health Sciences (HHS) manages the advancement of regional eHealth initiatives to improve the delivery of healthcare in the HNHB LHIN. The eHealth Office provides strategic planning, stakeholder engagement, communication, change management and adoption (CM&A), proposal preparation and negotiation, and integration planning and implementation for regional eHealth initiatives. As part of the Connecting South West Ontario (cSWO) Program, the eHealth team of HITS is responsible for deploying ClinicalConnect™ across the Erie St. Clair, South West, Waterloo Wellington and HNHB LHINs, as well as acting as the regional delivery partner for HNHB LHIN. As the Change Management & Adoption (CM&A) Delivery Partner, the HITS eHealth Office's role is to work with local health service providers to facilitate the business and technical adoption of cSWO Electronic Health Record (EHR) Program solutions and standards into the regular delivery of care.

Funding and support are provided by the Ontario Ministry of Health and Long-Term Care, eHealth Ontario and Canada Health Infoway, as well as from other regional healthcare partners.

The HITS eHealth Office manages a number of initiatives with the view to improve patient care and safety, support provincial strategies like Health Links, and to better integrate data and services electronically across the continuum of care.

ClinicalConnect™

ClinicalConnect is a secure web-based portal that provides physicians and clinicians with real-time access to their patients' electronic medical information from regional hospitals, Community Care Access Centres (CCACs) and Regional Cancer Programs in South West Ontario (SWO). It also integrates data from eHealth Ontario's Ontario laboratories information system (OLIS) and the Southwestern Ontario Diagnostic Imaging Network (SWODIN). ClinicalConnect is a fundamental tool in bridging the gap between disparate information systems spanning a wide geographical area and multiple regional healthcare facilities and is also the Regional Clinical Viewer for the connecting South West Ontario (cSWO) Program, funded by eHealth Ontario.

In 2015/16, a number of significant updates in terms of both data and functionality have been made to the portal. ClinicalConnect now aggregates data from 67 acute care hospitals (up from 50 last year), four CCACs, OLIS, and diagnostic images contributed by 58 hospital sites to SWODIN (up from eight sites' images last year). From a functionality perspective, a number of enhancements were made to ClinicalConnect over the course of the year. In September 2015, an integration with DynaMed® was completed, providing ClinicalConnect users from organizations in the HNHB LHIN (pilot project) with direct access from within ClinicalConnect to this evidence-based clinical information tool. Additional clinical information about disease names, conditions and prescription medications can be accessed by users to support their delivery of care, and the information presented takes into account the patient's age and gender. An evaluation of this integration is underway and the integration with DynaMed may be expanded to users in other SWO LHINs as part of a subsequent project. CCAC care plans are also now

available in ClinicalConnect from the South West and Waterloo Wellington CCACs. In December 2015, a new 'Frequent ED Visits' flag was implemented in the patient header of ClinicalConnect, to quickly identify patients who have had five or more visits to emergency departments at acute care facilities in SWO in the last 366 days. Also in December, the existing Health Links icon found in the patient header was updated to now only display for patients who have a Health Link Coordinated Care Plan initiated by a Health Link in the HNHB LHIN. From another Health Links perspective, the HITS eHealth Office CM&A team was involved in rolling out a pilot of the Ministry of Health's Coordinated Care Tool (CCT), which went live in three Health Links within the HNHB LHIN in Fall 2015. The HITS eHealth Office provided Project Management, Change Management, Education and Communications services to support the CCT pilot.

From a deployment perspective and thanks to aggressive change management and adoption efforts by eSWO Delivery Partners across the region, there are now almost 38,000 authorized ClinicalConnect users (up from 17,000 last year). In addition, almost all users from acute care facilities in the HNHB LHIN have access to ClinicalConnect directly from their hospital information system through contextual launch capability (as opposed to logging into the website separately), and this capability is being rolled out to hospitals across SWO as a result of a Canada Health Infoway-funded Single Sign On/Interoperability project with the HITS eHealth Office.

During 2015/16, other eHealth planning and/or implementation initiatives were pursued by the HITS eHealth Office including ClinicalConnect's integration with eHealth Ontario's Diagnostic Imaging Common Service, provisioning access to OLIS data via ClinicalConnect for more than 150 Participating Organizations and their sites across the cluster, integrating diagnostic images from the remaining hospitals in SWO, sending lab data from HNHB LHIN hospitals to OLIS, leveraging ClinicalConnect to allow users at acute care facilities to send referrals electronically to CCACs, and leveraging ClinicalConnect to provide notifications about patients' ED, inpatient and outpatient encounters at regional hospitals to CCAC and primary care providers. A project to develop a patient-facing portal, providing patients with electronic access to their medical records, has begun with funding for the planning phase provided by Canada Health Infoway. Contextual launch capability from other non-hospital information systems is being planned and/or rolled out to long-term care homes, as well as from within eSHIFT, an 'eHomecare' tool used by clinicians to remotely direct care through another provider at the patient's location. Other eHealth initiatives being explored include the rollout of eConsult functionality between physicians, using OTN's Personal Videoconference service to facilitate eVisits between physicians and patients, and becoming involved in Waterloo Wellington LHIN's Shared Coordinated Access initiative supporting Resource Matching & Referrals. Please visit www.HITSeHealth.ca for more detail about the projects listed above.

Hospital Report Manager (HRM)

In 2015, leveraging ClinicalConnect and in collaboration with OntarioMD (OMD), the HITS eHealth Office implemented the sending of transcription and radiology reports from Niagara Health System (June 2015) and Hamilton Health Sciences (December 2015) to Hospital Report Manager. This means HRM subscribers now receive those reports in their Electronic Medical Records (EMRs) from the two hospital systems for their patients. It's expected that all hospitals in the HNHB LHIN will be sending their transcription and radiology reports to HRM by the end of 2016, leveraging ClinicalConnect.

From a local deployment perspective and in collaboration with OMD, as of March 11, 2016, 156 clinicians in the LHIN are live with HRM with close to 300 more clinicians having signed agreements to subscribe to HRM. The HITS eHealth Office CM&A team continues working with existing ClinicalConnect EMR Download customers to begin the transition from EMR Download to HRM.

Integrated Decision Support (IDS) Business Intelligence Solution

IDS is a multi-LHIN integrated decision support data warehouse and business intelligence solution that provides for both system-wide and operational analytics to over 70 health service providers (HSPs) and LHIN offices. It consists of a live data repository, analytical tools and reporting services, and is operational in six LHINs (HNHB, Toronto Central, South West, Waterloo Wellington, Mississauga-Halton, and Erie St. Clair).

There are more than 1,000 active users in IDS, which houses more than 36.7 million patient encounter records (6 million unique patients) linked by a master LHIN number, facilitating collaboration between sectors that are responsible for the patients' healthcare journey. From an eHealth perspective, IDS complements existing initiatives, such as the rollout of ClinicalConnect, and can be used to provide analysis and insights into population health, patient risk segmentation, predictive analytics, Health Links, integrated bundled funding (IFM), and inform ecosystem development.

Change Management & Adoption in HNHB LHIN

As of February 2016, the HITS eHealth Office CM&A team had successfully onboarded users in the LHIN, including all 21 hospitals, more than 1,000 primary/secondary care organizations and other physicians' practices, over 100 community sector organizations and two of the five public health units. In this past fiscal year, the team trained more than 1,100 users. These eHealth transformation efforts will continue as "Train-the-Trainer" and "ClinicalConnect Champion" models are introduced throughout the organizations to ensure the long-term sustainability of ClinicalConnect and other eHealth solutions available to health service providers in the LHIN.

Improving System-wide Patient Flow and Timely Access to ED

Patient Flow

Patient flow is defined as an individual's movement through the health care continuum *(Source: Institute for Healthcare Improvement)*. Patient flow focuses on the transition of these individuals from the community to acute in-patient hospital care and acute in-patient care to post-acute care (like rehabilitation) or home. While it is not unexpected that situations will occur where individuals will experience a wait across the continuum, issues arise when individuals experience long waits in a hospital setting or when a large number of individuals wait in hospital for a post-acute care setting.

The LHIN measures overall patient flow in hospitals through two key performance indicators: Alternate Level

Provincial ALC Definition

"When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies)" *Source: Cancer Care Ontario*).

of Care (ALC) rate and Emergency Department (ED) Length of Stay (LOS).

ALC rate refers to the proportion of in-patient days in acute and post-acute hospital care settings that are spent as ALC in a specific time period.

In 2015-16, there were 106 fewer people waiting in hospital for an alternate level of care (441 in November 2015 compared to 547 in November 2014) and 17,257 fewer ALC days for the same reporting period *(Source:Access to Care (November 2015). ALC Trending Report).* This resulted in a 14% improvement in ALC Rate, going from 15.8% in fiscal year 2014-15 to 13.6% in 2015-16.

ED LOS reflects the total amount of time individuals spend in the ED, from the time they register or are triaged (whichever occurs first) to the time when they leave the ED or are admitted to an inpatient hospital bed. During this time, the person sees the medical staff and receives care.

How is ED LOS measured?
Hospitals report on the maximum amount of time in which 9 out of 10 patients completed their ER visit. The time the patient left the ER **minus** triage or registration time (whichever happens first) **equals** time spent in the ER (*Source: MOHLTC*).

There are nine hospital corporations within the LHIN; these include two academic centres, three large community hospitals (one multi-site), one chronic care hospital and three small community hospitals serving rural areas. Eight of these hospitals provide emergency services across twelve sites, of which eight ED sites participate in the MOHLTC's Pay for Results initiative and one sites has a dedicated ED for children and youth.

In 2015-16, the LHIN, in collaboration with the Emergency Services Steering Committee and HSPs, focused on reducing the ED LOS for the admitted patient population.

Improvements in the ED LOS time to inpatient bed has been noted at the following sites comparing previous fiscal year (2014-15) to Year to Date 2015-16 *(Source: Access to Care, January 2016. ER Fiscal Year Trending Report):*

- NGH – 15hrs -> 4.9hrs (67%)
- JBH – 46.5hrs -> 26.7hrs (48%)
- GNG – 43.5hrs -> 26.8hrs (38%)
- Welland - 32.72hrs -> 21.9hrs (33%)
- BCHS – 25.4hrs -> 20.6hrs (19%)

In addition to the ED LOS improvement in time to inpatient beds, the following was achieved:

- 24% improvement in overall ED LOS at Joseph Brant Hospital comparing fiscal year 2014/15 to Year to Date 2015/16 *(Source: Access to Care, November 2015. ALC Trending Report)*
- Recognition letters received in 2015 from the MOHLTC identifying outstanding performance ED performance by the following LHIN hospitals:
    - Greatest improvement in 90th percentile ED LOS:
        - St. Catharines General site – high volume hospital group
        - Greater Niagara General site – medium volume hospital group
        - Welland site – low volume hospital group
        - St. Joseph's Healthcare Hamilton – teaching hospital group
    - Lowest 90th percentile ED LOS:
        - Haldimand War Memorial Hospital – medium volume hospital group

Two key strategies to improve patient flow that were a focus in 2015-16 were the Transitional Care Program and Standardized Discharge Practices.

Transitional Care Program

The Transitional Care Program (TCP) introduced in October 2014 was expanded to 15 sites in 2015-16 for a total of 196 beds *(Source: CCAC Daily Idle Bed Report, March 24, 2016)* across Hamilton, Burlington, Niagara and Brant communities. The TCP program provides an alternative, community-based option for individuals ready for discharge from acute care hospital beds but who not ready or unable to return home to pre-hospital living arrangements. Individuals accessing the program are medically stable and ready for discharge from hospital. The program provides an environment that supports individuals to recover their strength and independence along with the time to be able to plan for the most appropriate permanent, community-based living arrangements.

The program has accumulated more than 27,977 days which translated to avoided Hospital ALC days.

The transitional bed programs are located in licenced retirement homes and assisted living environments where they provide access to appropriate care environments and services through a partnership with the CCAC. It is through these partnerships that individuals unable to return home following a hospital stay receive the right level of care while transitioning back to the community. Not only does this program provide a more appropriate care environment for the person in the community, it also improves overall patient flow in acute care hospitals which improves access to acute care services.

Standardized Discharge Practices

The HNHB LHIN has been and continues to be a strong supporter of a Home First Philosophy. Home First is an evidence-based philosophy that focuses on transition management and in supporting people to return home following a hospital stay.

In July 2014, the HNHB Patient Flow Steering Committee (PFSC), recognized the need to standardize discharge practices and processes across LHIN providers to improve patient flow. Key objectives of the Standardized Discharge Processes and Procedures are:

- Support patients to return home/access appropriate care prior to returning home, or moving to the next care destination;
- Improve communication and engagement with primary care providers;
- Greater consistency and collaboration of staff across organizations/sectors;
- Patients and families to be engaged early and often in the sharing of information about their care and development of supportive care plans; and
- Front-line and leadership working together to support patients access to care

Home and Community Care

On May 13, 2015, the ministry released *Patients First: A Roadmap to Strengthen Home and Community Care*, a three-year plan as an initial phase in transforming the way care in the home and community is delivered. The LHIN's strengths in identifying and planning local health care services and building effective collaborative community partnerships support the ministry's direction for Home and Community Care.

Collaborative Care Model for Personal Support Services

In 2015-16, the HNHB LHIN further expanded capacity of community support service (CSS) agencies to provide in-home personal support services. The HNHB LHIN, HNHB CCAC, and Assisted Living/Supportive Housing CSS agencies continued to work together to implement and refine the Collaborative Care Model (CCM) in alignment with both ministry guidelines for collaborating as "one sector" and the proposed standards from the provincial Early Adopter Work Group.

The CCM is directly aligned with the system priorities outlined in the ministry's Patient First strategy including integration, consistency, capacity, quality and value. The outcomes of this work will strengthen relationships between organizations, standardize and improve consistency in the quality and amount of care provided to individuals at home and in the community, enhance the capacity of CSS agencies to provide PSS, and improve integration across all sectors including primary and acute care.

In 2015-16 CSS agencies provided a total of 134,644 hours of personal support services to 1,784 individuals across the HNHB LHIN. Over 550 of these individuals were previously waitlisted for this level of personal support and now have access to this service. *(Source CCM Assisted Living Providers monthly reports).*

Integrated Comprehensive Care Program

A core strategy outlined in the Minister's Roadmap for Home and Community Care is "bundled care". In 2015-16, the HNHB LHIN worked closely with all HNHB acute hospital sites to implement the Integrated Comprehensive Care Program (ICCP). This model of care is based on the key elements of the St. Joseph's Healthcare Hamilton program of the same name that acts to strengthen the integration of health care services between hospital and the home/community. Starting at Joseph Brant Hospital, Hamilton Health Sciences and Brant Community Healthcare System, patients with Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF) are being enrolled in this program. As of March 2016, 73 clients have been enrolled in this program across 5 hospital sites. All LHIN hospitals will have implemented this service model in 2016-17.

To enhance this model, the HNHB LHIN and Ontario Telemedicine Network (OTN) are working with SJHH to pilot the integration of telehomecare into their existing ICCP care path for patients with COPD/CHF. Telehomecare offers remote patient monitoring that will provide patient-centered care and

care close to home, increase access to services for patients, and minimize the complexity of how care is organized and delivered. To date, 35 individuals have received telehomecare. Many have reported positive feedback and an evaluation will be conducted in 2016/17 to determine the overall impact of using this technology.

Personal Support Service Wage Stabilization

The HNHB LHIN implemented Phase 2 of the ministry's Personal Support Worker (PSW) Wage Stabilization Strategy in 2015-16. This strategy effectively set a minimum hour wage for individuals providing public funded personal support services in the community sector. In 2015-16, the LHIN provided over $8.4 million base funding to 29 LHIN funded agencies that provide personal support services.

Community Engagement

Given the recent emphasis on transformation of the home and community care sector in Ontario, the HNHB LHIN has identified an opportunity to engage with patients, their families and caregivers to understand public experiences and expectations of this sector. There were a number of mechanisms used to gather this information, which has resulted in changes in practice and modifications to models of care:

> "The personal support worker that look after my father are very nice, not only to him but to our family as well. My father really enjoys his visits"
> *Anonymous, (Patient Satisfaction Survey 2015)*

- Patient satisfaction surveys were administered to all individuals who were served by CSS agencies as part of the CCM:
    - 96.3% satisfied or very satisfied with the recent change to a new in-home care provider (n=883)
    - 97.7% satisfied or very satisfied with the level of dignity and respect received from their new in-home care provider (n=886)
    - 95.8% satisfied or very satisfied with the level of involvement in making care decisions related to care received from new in-home care provider (n=878)
    - 95% rated the quality of care from their new in-home care provider as 7 or above on a scale of 1 to 10 (n=632; clients who were transitioned from CCAC to CSS only)
    - 99.5% would recommend the personal support services provided by their CSS agency to family or friends (n=216; clients who were previously waitlisted only)
- Focus groups were conducted with clients and families related to the transition from CCAC to CSS for home and community care. Feedback was used to adjust future strategy for transitioning clients within the CCM.
- The HNHB LHIN engaged with The Change Foundation to host a number of engagement sessions with front-line professionals in home and community care, acute care, mental health (MH) and primary care to understand their experiences with family caregivers and how they may be supported or improved. This work is informing future planning related to family, caregiver and patient experiences within the HNHB LHIN and provincially.

MLAA Performance Indicators

Figure 13: MLAA Performance Indicators

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
1. Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	89.37%	90.49%	90.80%
The HNHB LHIN improved performance on this indicator in 2015/16 compared to 2014/15 and continues to outperform the provincial average by over 5%. However, the provincial target has not yet been achieved. The HNHB CCAC is responsible for coordinating personal support services to clients with complex needs and can receive referrals from both the hospital and the community. A higher proportion of referrals from hospital were visited within 5 days of authorization compared to referrals from the community. The HNHB LHIN is working with the HNHB CCAC to understand factors influencing authorization to first visit times and identify areas for improvement. In 2015/16, the HNHB LHIN expanded capacity in the community for individuals requiring low to moderate personal support services under the Collaborative Care Model (CCM). Under this model, the HNHB Community Care Access Centre (CCAC) and designated LHIN-funded Assisted Living/Supportive Housing CSS agencies work as one sector for the provision of in-home PSS. By expanding community capacity to serve individuals with low to moderate personal support needs, the CCAC was able to accommodate more clients with complex needs.							
2. Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	92.67%	93.47%	93.32%
The HNHB LHIN improved performance on this indicator in 2015/16 compared to 2014/15. Although comparable to the provincial average, the HNHB LHIN has not yet achieved the provincial target. The HNHB CCAC receives referrals for nursing from the community and hospital and both have relatively identical rates for a nursing visit within 5 days of authorization. The CCAC has identified improvement in this metric on their corporate work plan and they continue to closely monitor performance. In 2015/16, it was identified that the ICC program was negatively impacting performance on this metric, because individuals were being authorized for nursing services prior to being discharged from the hospital and making it difficult to see some clients at home within 5 days. In January 2016, a process was put in place to mitigate this impact, which will improve average performance on this metric in 2016/17.							

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
3. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	30.00	23.00	24.00	25.00
The HNHB LHIN performance for this indicator has slightly worsened over the 2015/16 fiscal year. Although still performing 5 days (on average) better than the provincial for this indicator, the HNHB LHIN is still not meeting the provincial target. The wait time for this metric is divided into two intervals: "referral to authorization" and "authorization to first service". HNHB LHIN performance on authorization to first service remained stable throughout the 2015/16 fiscal year at 7 days. However, performance on referral to authorization has decreased by 4-5 days since the LHIN was meeting this target. The CCAC has identified a few key drivers of this increase: (1) Clients can be authorized for service and then waitlisted; (2) Earlier referrals from hospital are sometimes accompanied by delayed hospital discharge; and, (3) Increased complexity of the services that need to be coordinated. The HNHB LHIN is working with the HNHB CCAC and other health system partners to improve performance on this metric.							
4. 90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	10.48	9.97	13.28	13.45	12.83
In 2015-16, the HNHB LHIN improved the 90th percentile ED length of stay (LOS) for complex patients by 4% or 27 minutes. The hospital sites with the greatest improvements in this metric were JBH – 30% improvement (22.2hrs to 15.7hrs), BCHS – 17% improvement (13.9hrs to 11.6hrs), and SJHH – 10% (13.2hrs to 11.8hrs). The 90th percentile ED LOS metric includes both admitted (CTAS I-V) and non-admitted (CTAS I-III). In 2015-16, the HNHB LHIN met MLAA target of 8hrs for the non-admitted high acuity population (7.3hrs), but exceeded the 8 hr target for the admitted population (30.2hrs). The HNHB LHIN and the Emergency Services Steering Committee (ESSC) focused on improving ED LOS for the admitted population in 2015-16 and were able to realize a 12% improvement over 2014-15 (34.5hrs to 30.2hrs). Sites with the greatest improvement in this population included: JBH – 39% (54.8hrs to 33.2hrs), NHS Welland site – 29% (45.8hrs to 32.5hrs), and NGH – 28% (21.1hrs to 15.2hrs). Hospital sites will continue to focus on improving ED LOS for the admitted population in 2016-17, which will result in improving this metric. Challenges: • Demand: continued year over year increase in ED visits. The LHIN EDs experienced 16,833 more ED visits in 2015-16 over 2014-15 • Complexity: 74% of all ED visits in 2015-16 were complex • Admission rates: 13% admission rate (2nd highest admission rate among 14 LHINs) • Population: 58% of complex ED visits were individuals 65+, 39% admitted to hospital							

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
5. 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.28	4.07	4.50	4.68	4.55
In 2015-16, the HNHB LHIN did not meet the ML AA target of 4hrs for the non-admitted ED LOS for minor/uncomplicated patients by 33 minutes, relatively unchanged from 2014-15 (3 minutes). Two sites reported LOS lower than the provincial 4hr target: HWMH 2.1hrs and NHS Greater Niagara site 3.6hrs, while the remaining 10 sites exceeded target (ranging from 4.3hrs at BCHS & NHS St. Catharines site to 6.3hrs at JBH). Increased volume of higher acuity ED visits competing for the same ED resources and primary care access in the community continue to be identified as challenges to meeting this target. Site specific strategies to improve this metric in 2015-16 include: early intervention screening with Senior's Mobile Assess Restore Team (SMART), improvements in diagnostic imaging (DI) access and turnaround times to improve flow, review of physician hours, Kaizen events to establish new models of care in ED with staged implementation, increasing RN staff to peak volume times.							
6. Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	47.97%	44.45%	47.48%
The LHIN exceeded provincial performance by 9.07% in 2015-16, and by 4.08% in the most recent quarter, but fell short of the provincial target for this metric. LHIN performance reflects the provincial challenge hospitals have in meeting patient and physician demand for MRI. Over the last year, hospitals have strived to complete scans for patients with higher medical priorities more quickly (Priority (P) 1 and P2 scans), than those of lower medical urgency (P3 and P4 scans). In the 4th quarter of FY 2015-16, 84.5% of P2 scans were completed within target, exceeding the performance of lower priority P3 and P4 scans. While there has been success in completing more urgently needed scans sooner for patients this change in focus results in non-urgent scans waiting longer. The Diagnostic Imaging Steering Committee is in the final stages of development of a common MRI referral form and is developing protocols for rapid MRI scans to improve scanner efficiencies, and allow more patients to received scans.							
7. Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	74.99%	60.63%	68.89%
Patients requiring CT scans had to wait longer in the last 2 quarters of this Fiscal Year compared to the prior year. This has resulted from continued increases in demand for CT scans from physicians. Patients with higher medical needs for scans (P2 scans) have met and exceeded the provincial target by completing 93.81% of P2 scans within the target wait times. The most medically urgent patients continue to be prioritized for CT scans first. Due to the increase in demand for CT scans over the course of FY 2015-16 it has become increasingly challenging to meet the demands of P3 and P4 scans for patients. The Diagnostic Imaging Steering Committee continues to look for opportunities to implement Choosing Wisely Canada recommendations to reduce any potentially inappropriate CT scans. The Niagara Health System has lead collaborative Choosing Wisely Canada evidence-based recommendations with their emergency department to attempt to increase the appropriateness of care and use of CT with good success. New information available through the Wait Time Information System upgrade for CT will allow for more detailed analysis of CT performance in the future and highlight opportunities for performance improvement.							

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
8. Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	75.06%	76.14%	79.22%
The HNHB LHIN improved in performance in this metric by 4.16% compared to FY 14/15. HNHB LHIN performance is within 1% of provincial performance. Orthopedic directors at each site regularly review wait list information to ensure appropriate plans are put in place to manage patients who are waiting longer than the target. Surgeon participation in the Regional Joint Assessment Program is encouraged to ensure patients are offered and provided the first available surgical date. Factors contributing towards ongoing challenges in meeting provincial target include: primary care referral patterns, patient preference for specific site and/or surgeon, an increasing backlog of patients waiting for surgery and increasing volume of new patients added to wait lists. Guided by the Orthopedic Leadership Steering Committee, initiatives have been put in place to reduce variation in wait times and ensure quality of care. The steering committee is in the final stages of a review of LHIN wide total hip and knee arthroplasty care to look for further opportunities to improve performance.							
9. Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	72.25%	68.70%	75.32%
The HNHB LHIN improved performance in this metric by 3.07% compared to FY 14/15. Orthopedic directors at each site regularly review wait list information to ensure appropriate plans are put in place to manage patients who are waiting longer than the target. Surgeon participation in the Regional Joint Assessment Program is encouraged to ensure patients are offered and provided the first available surgical date. Factors contributing towards ongoing challenges in meeting provincial target include: primary care referral patterns, patient preference for specific site and/or surgeon, an increasing backlog of patients waiting for surgery and increasing volume of new patients added to waiting lists. Guided by the Orthopedic Leadership Steering Committee, initiatives have been put in place to reduce variation in wait times and ensure quality of care. The steering committee is in the final stages of a review of LHIN wide total hip and knee arthroplasty care to look for further opportunities to improve performance.							
10. Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	18.23%	16.06%	16.33%
In 2015-16, the HNHB LHIN improved the Percent ALC Days by 10% over 2014-15. The HNHB LHIN continues to work on a number of strategies to improve overall patient flow. These include, but are not limited to: (1) Standardized evidence-based discharge practices including early discharge planning (48 hour conversation), alternate level of care (ALC) avoidance, and incorporating Estimated Discharge Date (EDD) into discharge practices; (2) Hospital site-specific strategies: daily huddles, bed mapping, value stream mapping, admit avoidance, geographic physician models; (3) Increased community capacity: continued expansion of the HNHB Transitional Care Program (TCP) located in Registered Retirement homes and Assisted Living settings that provide access to personal supports 24 hours a day in congregate settings. The TCP program provides an alternative, community-based option for individuals ready for discharge from acute care hospital beds but who are unable to return home to pre-hospital living arrangements. The program provides an environment that supports individuals to recover their strength and independence along with the time to be able to plan for the most appropriate permanent, community-based living arrangements; and (4) Continued focus on long-stay population: through ongoing monitoring and standardized complex case resolution process. Percent of ALC days is often influenced by the closure of long wait cases. Long wait cases in the HNHB LHIN include: Long-Term Care (which can be influenced by choice, a history of responsive behaviours), Group Homes for individuals with a developmental disability, and Specialized Programs (provincial ventilation beds, behavioural support transition units), and individuals designated ALC in acute with no discharge destination (e.g. patients with care needs that exceed levels provided in post-acute hospital settings, community, and LTC).							

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
11. ALC rate	12.70%	13.70%	14.12%	13.98%	15.78%	13.49%	13.61%
The HNHB LHIN saw a sustained improvement in ALC rate throughout 2015-16 and remained within 10% of meeting the provincial target of 12.7%. The HNHB LHIN continues to work on a number of strategies to improve overall patient flow. These include, but are not limited to: (1) Home First; (2) Hospital site specific strategies; (3) Increased community capacity: continued expansion of the HNHB Transitional Care Program (TCP); (4) Continued implementation and investment in the Home and Community Support Model – a collaborative care model focusing on transitioning stable clients with low to moderate personal support services (PSS) needs from CCAC to Assisted Living providers, while allowing CCAC to focus on increased referrals from hospital and community needing higher levels of care and case management; (5) Continued implementation and spread of Integrated Comprehensive Care (ICC) model across all hospital sites; (6) Expansion of Behaviour Support Ontario (BSO) Clinical Leads in hospital (up to three) to work with LHIN hospitals to address barriers to discharge individuals with a history of responsive behaviours; and (7) Prevention of physical decline through early intervention programs like the Seniors Mobile Assess and Restore Teams (SMART).							
12. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	18.59%	18.61%	18.46%
In 2015-16, the HNHB LHIN did not meet the provincial target of 16.3%. The LHIN did, however, make modest improvements in comparison to 2014/15. The HNHB LHIN's performance is better than the provincial performance. The launch and/or expansions of the Mobile Crisis Rapid Response Teams across the LHIN in the year likely contributed to the modest improvements and a bigger effect is expected in the 2016/17 fiscal as these programs continue to divert individuals from Emergency Departments as appropriate to other resources. Brantford had launched in the previous fiscal in January 2015. The Hamilton expansion of the initial team to 7 days per week and launch of the second full team started April 2015, Norfolk's team launched in May 2015, Niagara launched July 2015, and Halton started in December 2015. The HNHB LHIN also continued funding of an Early Intervention Coordinator in order to implement the Youth Wellness Centre model in order to ensure early intervention with youth who are experiencing mental health and substance use concerns and spread the model across the HNHB LHIN.							
13. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	27.11%	30.82%	29.79%
In 2015/16, the LHIN did not meet the provincial target of 22.4%. The HNHB LHIN performance declined in 2015/16 compared to 2014/15 on this performance indicator, however, did improve better in 2015/16 than the provincial performance. The continuation of funding of a HNHB LHIN Concurrent Disorders Implementation Coordinator occurred in order to bring health service providers together to develop common local approaches to treat concurrent disorders (where a mental health and addiction issue co-occur) and to build capacity in our health service providers through education and locally driven improvement projects. This should help increase the capacity of our health service providers to provide the right care, at the right place, at the right time and reduce the need for emergency services. The HNHB LHIN also continued funding of an Early Intervention Coordinator in order to implement the Youth Wellness Centre model in order to ensure early intervention with youth who are experiencing mental health and substance use concerns and spread the model across the HNHB LHIN.							

Performance Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
14. Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	16.50%	16.51%	16.47%

HNHB LHIN performance on this indicator, although better than the provincial average, remains above the provincial target. From Q3 2014/15 to Q2 2015/16, the HIG conditions that negatively impacted performance for this metric are CHF, COPD and AMI, with average 30-day readmission rates of 22.6%, 19.1%, and 17.3%. Additionally, 35% of total readmissions in the HNHB LHIN from Q3 2014/15 to Q2 2015/16 were due to the Gastrointestinal HIG, which had an average 30-day readmission rate of 17.2%. To achieve the provincial target, improvements must be made in the Gastrointestinal HIG.

The HNHB LHIN is leading several key initiatives aimed at improving performance on 30-day readmissions. The Integrated Comprehensive Care (ICC) program will be launched in all acute care hospital sites by 2015/16, which will strengthen the integration of services between hospital and home care services and lead to improved patient outcomes. The ICC program will also integrate with Caring for my COPD, which is a community-based program for enhancing self-management of COPD. In 2015/16, a robust evaluation of the Caring for my COPD program was initiated and the results will be available in 2016/17. Recommendations for performance improvement will be included in this evaluation report. Additionally, the Health Links strategy continued to scale and spread its implementation in 2015/16, with 957 coordinated care plans developed by March 2016. Health Links is coordinating care for individuals who frequently access emergency services often because their needs are not being met in the community. Finally, the LHIN has focused on collaboration and partnerships between HSPs in 2015/16 to enhance access and coordination to services for individuals with diabetes.

Monitoring Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
15. Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	77.52%	81.70%	81.44%

Over the past year, we have continued to work with our various hospital sites to improve OR efficiencies and work with individual surgeons on their coding practices. The Regional Oncology Steering Committee regularly reviews quarterly performance targets and shares learnings, best practice, and opportunities across the HNHB LHIN. Over the past year, we have seen increases in new cases of breast, gastrointestinal, prostate, gynecological, and head and neck cancers. Newly recruited surgeons (colorectal, gynecology, hepatobiliary) are beginning to improve our surgical wait times. We continue to see longer wait times for prostate surgery, as the demand for the Robotic Prostate Procedure continues to impact wait times and we do not foresee any immediate improvement in this Robotic wait time. Reconstruction surgery at the time of initial breast surgery affecting wait times.

16. Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	99.69%	100.00%	99.00%

The HNHB exceeded the MLPA target for this metric. The LHIN closely monitors factors that could impact wait times for cardiac surgery such as hospital patient flow pressures.

Monitoring Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
17. Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	84.78%	87.23%	85.21%
Two out of five facilities exceeded the target for FY 2015-16. There was a slight improvement in HNHB performance compared to last year. Hospital providers and data continue to show that demand for this service exceeds the supply of surgeries available through the Quality-Based Procedure allocation to the HNHB LHIN. This has negatively impacted wait times for our residents and attempts to clear the backlog of cases continue. The LHIN Vision Leadership Committee has worked to decrease the variation in wait time among facilities by increasing transparency of wait time information and encouraging referral redirect to surgeons with shorter wait times. With support of the Vision Leadership Committee, providers are focusing on booking patients with a higher priority and ensuring longest wait cases within each priority group are booked first. Facilities have balanced surgical volumes over the course of the year eliminating prior concerns of front-loading of surgeries.							
18(a). CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	9.00	10.00	9.00
The LHIN performance reported that individuals assessed in the community wait 10 days from application to eligibility determination for long-term care placement. This exceeds the provincial average by 5 days. The CCAC continues to work with individuals and caregivers to make educated, well-informed decisions before care destinations are chosen.							
18(b). CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	6.00	6.00	6.00
The LHIN performance reported that individuals wait 6 days in acute care settings from application to eligibility determination for long-term care home placement. This exceeds the provincial average by 1 day. Work continues with CCAC and hospitals to facilitate the assessment and discharges for individuals who need long-term care. Strategies to meet this target in hospital include: Home First Initiatives, patient flow rounds with hospital flow managers and CCAC, and BSO clinical support to aid in the placement of individuals with responsive behaviors.							
19. Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	22.27	4.89	13.69
The LHIN performance on this indicator has improved by 8.58 per 1,000 population from fiscal year 2014/15 to fiscal year 2015/16 and continues to approach provincial performance. The LHIN has worked with early adopter hospitals to develop admission avoidance strategies, with potential to spread to all hospital sites within the LHIN. Continued engagement with primary care physicians, as well as implementation of the Integrated Comprehensive Care model has contributed to improvement in this indicator.							

Monitoring Indicator	Provincial target	Provincial			LHIN		
		2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
20. Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	389.33	102.84	290.06
The LHIN performance on this indicator has improved by 99.27 per 100,000 population from fiscal year 2014/15 to fiscal year 2015/16., however, the LHIN hospitalization rate for ambulatory care sensitive conditions continues to remain above the provincial average. The LHIN has improved performance on this indicator through participation in primary care engagement and continued Health Links implementation.							
21. Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	47.71%	47.23%	47.92%
The LHIN performance on this indicator improved from fiscal year 2014/15 to fiscal year 2015/16 and exceeds provincial performance by 1.34%. The LHIN has implemented the Discharge Transition Bundle and the Integrated Comprehensive Care Program across all hospital sites, where a primary care physician visit is booked for the patient as part of the discharge planning process, where possible. The LHIN has also started to implement E-Notification at discharge in Niagara so that primary care physicians receive electronic notification from the hospital that their patient is discharging to the community.							

**FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)*

***FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)*

Financial Statements and Notes

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2016

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2016

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Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2016 and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 25, 2016

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	$	$
Financial assets		
Cash	1,062,371	868,913
HST receivable	21,831	25,366
Accounts receivable - other	85,256	180
Due from Ministry of Health and Long-Term Care ("MOHLTC") transfer payments to Health Service Providers ("HSPs") (Note 9)	31,249,618	22,453,844
	32,419,076	23,348,303
Liabilities		
Accounts payable and accrued liabilities	262,301	213,956
Due to the MOHLTC (Note 3b)	913,720	725,631
Due to Health Service Providers ("HSPs") (Note 9)	31,249,618	22,453,844
Due to the LHIN Shared Services Office (Note 4)	2,601	81
Deferred capital contributions (Note 5)	21,659	43,958
	32,449,899	23,437,470
Commitments (Note 6)		
Net debt	(30,823)	(89,167)
Non-financial assets		
Prepaid expenses	9,164	45,209
Tangible capital assets (Note 7)	21,659	43,958
Accumulated surplus	-	-

Approved by the Board

_____ Chair

_____ Vice-Chair

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of operations
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	2,884,971,100	2,941,067,069	2,895,775,446
Operations of LHIN	4,916,172	4,599,809	4,897,490
Project Initiatives			
Enabling Technologies for Integration Project Management Office ("ETI PMO") (Note 4)	510,000	510,000	510,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	106,000
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	75,000	75,000
Critical Care LHIN LEAD	-	75,000	75,000
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	824,475	841,301
Physiotherapy	-	-	-
Amortization of deferred capital contributions (Note 5)	-	38,662	43,893
	2,890,434,772	2,947,920,208	2,902,948,323
Funding repayable to the MOHLTC (Note 3a)	-	(188,089)	(725,631)
	2,890,434,772	2,947,732,119	2,902,222,692
Expenses			
Transfer payments to HSPs (Note 9)	2,884,971,100	2,941,067,069	2,895,775,446
General and administrative (Note 11)	4,916,172	4,452,413	4,228,189
Project Initiatives (Note 10)			
ETI PMO	510,000	510,000	510,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	106,000
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	72,969	73,478
Critical Care LHIN LEAD	-	75,000	72,599
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	824,475	832,787
	2,890,434,772	2,947,732,119	2,902,222,692
Annual surplus and closing accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of change in net debt
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	36,045	(37,277)
Acquisition of tangible capital assets	-	(16,363)	(18,681)
Amortization of tangible capital assets	-	38,662	43,893
Increase in net debt	-	58,344	(12,065)
Net debt, beginning of year	-	(89,167)	(77,102)
Net debt, end of year	-	(30,823)	(89,167)

The accompanying notes to the financial statements are an integral part of these financial statements

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	38,662	43,893
Less items not affecting cash		
Amortization of deferred capital contributions	(38,662)	(43,893)
Changes in non-cash operating items		
Accounts receivable - other	(85,076)	762
HST receivable	3,535	6,839
Due from MOHLTC to HSPs	(8,795,774)	26,996,401
Accounts payable and accrued liabilities	48,345	(153,554)
Due to the MOHLTC	188,089	297,216
HSPs from MOHLTC	8,795,774	(26,996,401)
LHIN Shared Services Office	2,520	(2,026)
Prepaid expenses	36,045	(37,277)
	193,458	111,960
Capital investment		
Acquisition of tangible capital assets	16,363	(18,681)
Financing transaction		
Capital contributions received	(16,363)	18,681
Net change in cash	193,458	111,960
Cash, beginning of year	868,913	756,953
Cash, end of year	1,062,371	868,913

The accompanying notes to the financial statements are an integral part of these financial statements

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2016

1. **Description of business**

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry - LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2016.

The LHIN has also entered into an Accountability Agreement with the MOHLTC, which provides the framework for LHIN accountabilities and activities.

The LHIN statements do not include any MOHTLC managed programs.

2. **Significant accounting policies**

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. **Significant accounting policies (continued)**

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. **Significant accounting policies (continued)**

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. **Funding repayable to the MOHLTC**

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2016 Excess funding	2015 Excess funding
	$	$	$	$
Transfer payments to HSPs	2,941,067,069	2,941,067,069	-	-
LHIN operations	4,638,471	4,452,413	186,058	713,194
ETI PMO	510,000	510,000	-	-
French Language Planning Entity	411,693	411,693	-	
French Language Services	106,000	106,000	-	
ER/ALC Performance Lead	100,000	100,000	-	-
Emergency Dept. LHIN LEAD	75,000	72,969	2,031	1,522
Critical Care LHIN LEAD	75,000	75,000	-	2,401
Primary Care Lead	75,000	75,000	-	-
Aboriginal Planning	37,500	37,500	-	-
Diabetes Education	824,475	824,475	-	8,514
	2,947,920,208	2,947,732,119	188,089	725,631

b) The amount due to the MOHLTC at March 31, 2016 is made up as follows:

	2016	2015
	$	$
Due to MOHLTC, beginning of year	725,631	428,215
Funding repayable related to current year activities to the MOHLTC (Note 3a)	188,089	725,631
Amount recovered by the MOHLTC during the year	-	(428,215)
Due to MOHLTC, end of year	913,720	725,631

4. **Related party transactions**

LHIN Shared Services Office, Local Health Integration Network Collaborative

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

Enabling Technologies for Integration Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with South West, Erie St. Clair and Waterloo Wellington LHIN's (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from the South West LHIN of $510,000.

5. **Deferred capital contributions**

	2016	2015
	$	$
Balance, beginning of year	43,958	69,170
Capital contributions received during the year	16,362	18,681
Amortization for the year	(38,661)	(43,893)
Balance, end of year	21,659	43,958

6. **Commitments**

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due under existing leases are as follows:

	$
2017	172,786
2018	172,786
2019	71,994

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. **Tangible capital assets**

	Cost	Accumulated amortization	2016 Net book value	2015 Net book value
	$	$	$	$
Office, equipment, furniture and fixtures	494,740	(478,224)	16,516	8,499
Computer equipment	248,908	(243,765)	5,143	35,459
Leasehold improvements	572,444	(572,444)	-	-
	1,316,092	(1,294,433)	21,659	43,958

8. **Budget figures**

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of operations reflect the initial budget at April 1, 2015. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,941,067,069 is derived as follows:

	$
Initial budget	2,884,971,100
Adjustment due to announcements made during the year	56,095,969
Final budget	2,941,067,069

The final LHIN general and administrative budget of $7,130,840 is derived as follows:

	$
Initial budget	
LHIN operations	4,916,172
ETI PMO	510,000
Aboriginal Planning	37,500
Additional funding received during the year for:	
French Language Planning Entity	411,693
French Language Services Coordinator	106,000
ER\ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
Primary Care Lead	75,000
Diabetes Education	824,475
Final budget	7,130,840

9. **Transfer payments to HSPs**

The LHIN has authorization to allocate funding of $2,941,067,069 (2015 - $2,895,775,446) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2016 as follows:

	2016	2015
	$	$
Operations of hospitals	1,933,929,144	1,914,168,474
Grants to compensate for municipal taxation - public hospitals	462,000	464,700
Long-term care homes	487,760,279	478,905,154
Community care access centres	311,792,567	307,373,115
Community support services	52,497,726	47,447,841
Acquired brain injury	7,549,178	7,619,608
Assisted living services in supportive housing	35,752,550	34,857,366
Community health centres	29,277,055	28,958,381
Community mental health addictions program	82,046,570	75,980,807
	2,941,067,069	2,895,775,446

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2016 an amount of $31,249,618 (2015 - $22,453,844) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's operations and is included above.

10. **Project initiatives**

The LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object.

	2016	2015
	$	$
Salaries and benefits	902,803	894,626
Professional services	1,206,825	1,201,529
Shared services	36,000	41,000
Occupancy	37,000	38,687
Supplies	10,790	13,079
Mail, courier and telecommunications	10,438	18,194
Other	8,781	11,942
	2,212,637	2,219,057

Diabetes strategy operational expenses included in the project initiative expenses above are as follows:

	Actual 2016	Actual 2015
	$	$
Salaries and benefits	717,701	717,701
Others	106,774	115,086
	824,475	832,787

11. Expenses by object

The Statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2016	2015
	$	$
Salaries and benefits	3,421,040	3,107,790
Board Chair per diems	26,425	19,425
Directors' per diems	32,559	24,396
Board expenses	9,654	7,913
Travel	19,164	19,268
Consulting services	127,301	78,279
Community forums and communication	43,340	40,281
Supplies, equipment, maintenance, other	56,942	55,801
Occupancy costs	284,161	319,080
Amortization	38,662	43,893
Shared services	393,164	512,063
	4,452,412	4,228,189

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 40 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2016 was $330,651 (2015 - $282,948) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2015. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

Board Members

(as of March 31, 2016)

Michael Shea
Chair

Mervin Witter
Vice Chair

Laurie Ryan-Hill
Vice Chair

Helen Mulligan
Board Member

Bill Thompson
Board Member

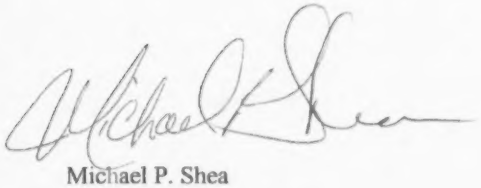
Dominic Ventresca
Board Member

Madhuri Ramakrishnan
Board Member

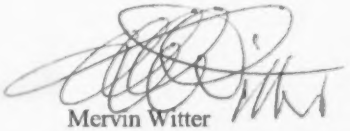
Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2016.



Michael P. Shea
Chair, Board of Directors



Mervin Witter
Vice Chair, Board of Directors

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